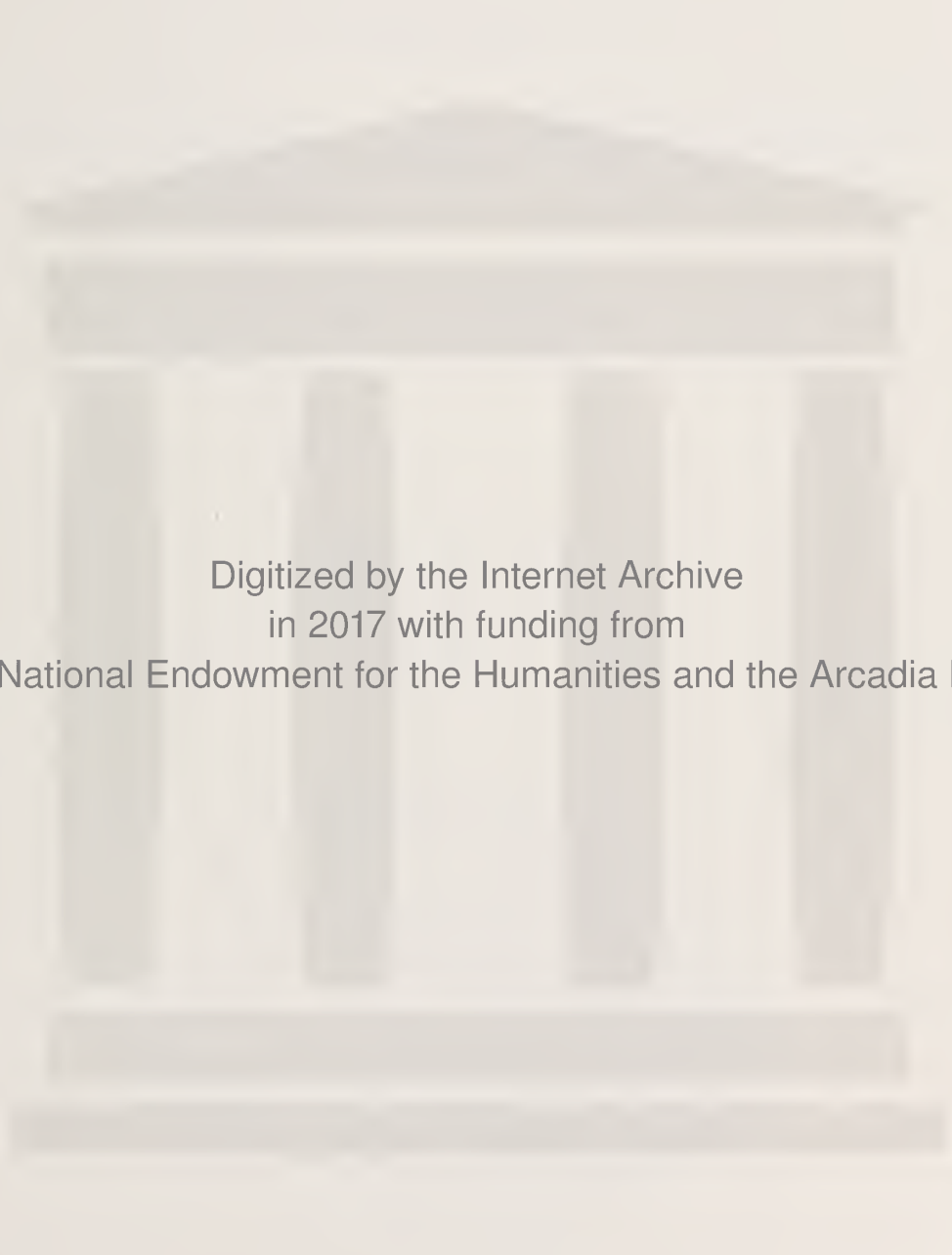


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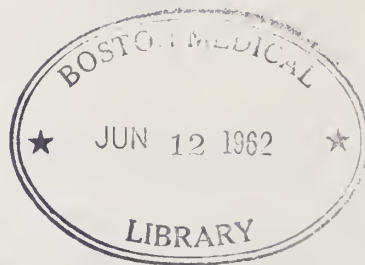
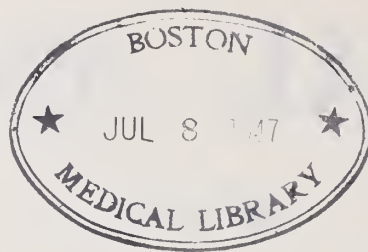
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THE NATIONAL PROGRAM FOR PHYSICAL FITNESS*

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THE NATIONAL OBJECTIVE

THE national objective in physical fitness is the development and maintenance of maximum health and vigor of body, mind and spirit of each individual from the cradle to the grave. This can only be obtained through the harmonious coöperation of vigorous bodies and well-trained minds in the building of character and personality to meet the demands of modern civilization and the political demands of American citizenship. To the individual this will mean more zestful living and a more abundant life. To the Nation it means a citizenry capable of better family, community and state relations and national and global leadership. Since America is predestined to play a major role in world leadership, her people must fit themselves adequately for this challenge—physically, mentally and morally.

WE HAVE NOT HEEDED THE KNOWLEDGE WE HAVE

Many of us believed that this Nation was the healthiest, most vigorous, rugged and virile in the world. In some respects this is true; but we have not heeded national surveys which have

repeatedly revealed weaknesses in the field of health and fitness and we have not translated, heretofore, this knowledge into constructive plans and corrective action. The statistics of World War I revealed that all was not well with the Nation at that time. Adequate recognition and correction were not accorded these figures and the situation was allowed to drift. A national health survey conducted by the United States Public Health Service revealed a problem of similar magnitude, which likewise has gone unheeded. Selective Service statistics of World War II have revealed a similar or perhaps an even worse situation. Failure to act, in this situation, will permit further deterioration in our public and individual health.

THE FIGHTING FORCES OF THE U. S. A.

This country has raised the largest and best fighting force of its history, perhaps in the history of all time. In the process it has revealed the prevalence of defects, deficiencies, disabilities, disorders and diseases in the Nation. It has revealed also the incapacity of the Nation to correct expeditiously this situation through civilian channels. Finally the efficiency of the fighting forces was conserved and promoted by setting

*Read at the Sixteenth Annual Scientific Assembly of the Society, October 7, 1944.

up within the services themselves corrective measures in the fields of medicine, dentistry and education.

MAKING A PHYSICALLY FIT ARMY

How was it possible, one might rightly ask, to create such a tremendous and superb fighting force from a Nation with so many individuals with defects, disabilities and disorders? The answer is simple. It was accomplished through a carefully planned and administered series of procedures of selection and rejection, training, and discharge. Selection, by Selective Service local boards and the armed forces induction stations, brought to the fighting forces only those who were most healthy and most fit. Rejection turned back to civil life all those considered incapable of serving the armed forces to advantage. Training developed a higher degree of health and physical fitness in those already found competent. Discharge removed from the fighting forces those proving themselves incapable of serving to advantage. By these processes our military forces were made efficient and great.

MILITARY ACHIEVEMENT IN PHYSICAL FITNESS SHOULD STIMULATE CIVILIAN EFFORT

The military authorities demanded health and physical fitness of its personnel. They provided for its development to the level of the military needs. Although it is admitted that the physical levels for military service are somewhat higher than those for civil life, the physical fitness obtained by our fighting forces may well constitute clear evidence that intelligent planning and constructive action make great achievements possible in this field.

THE INTEREST IN THE INDIVIDUAL

We should not forget that we are basically concerned with individual health. The test of the whole program will be the effect on the individual. The improvement of community conditions in public sanitation and health is

designed to better the health of the individuals who live in the community. School programs are to help school children and, indirectly, their families. We must never lose sight of the individual.

A GROWING NATIONAL CONSCIOUSNESS

There has been a greater national consciousness of the need for national physical fitness than at any time in recent history. We seem to take more to heart the meaning of the physical unfitness of so many of our young men for military service. Even during the war, proposals have been made by the President for rehabilitation of registrants. Likewise prehabilitation has been advocated. State educational departments and individual school systems have undertaken helpful steps to aid the war effort. Industrial personnel departments have, in the interest of production, coöperated in building up individual health. There are many signs of this awakening of national consciousness on this problem of health and physical fitness. The war measures are temporary makeshifts and often incidental. We need to bring this national consciousness to sharper focus. We need to inform it. We need to outline practical steps. There is need for national organization, and I shall tell you later about it. And there is need for local organization and leadership. Let us look at the wartime situation and the detailed facts.

CURRENT STATISTICS REVEAL PRESENT NEEDS

The present national movement of physical fitness is based on the need currently demonstrated. Medical examinations incident to induction have resulted in approximately 4,000,000 rejections of the 13,000,000 men ages 18 to 37 examined up to January 1944. To a certain extent this serves to reveal the medical needs though a more accurate index is provided in Selective Service statistics covering the incidence of defects. This reveals the coexistence of more than one defect in a large proportion of those

rejected. In addition to the figures for rejection, the figures for discharge from the service on Certificates of Disability must be included. This has amounted to hundreds of thousands. Conservatively it can be stated that the figure for those discarded for military service, by rejection or by discharge, as unfit, now surpasses 5,000,000 of the approximately 13,000,000 examined up to January 1944. This would indicate that in this country about 2 out of 5 young men of military age examined have been adjudged unfit for military service. In relation to these figures, one must take into consideration: (1) that the standards for admission have been lowered to the absolute minimum requirements, (2) that the fighting forces have accepted many men for limited service only, and (3) that the fighting forces have had created within the service, personnel and facilities to carry out great programs of rehabilitation in the field of dental defects, illiteracy, hernia and venereal disease.

THE NATIONAL MOVEMENT: WHAT HAS BEEN ACCOMPLISHED

The present movement has been under way over a period of three years. Progress has been slow, especially in the beginning in that period which might be regarded as the time of seeding. This covered a period of two years. Only recently have some things begun to sprout. Several steps may be enumerated:

(1) Selective Service published statistics on rejections in the summer of 1941, emphasizing the fact that 50 per cent of the registrants examined failed to qualify by reason of physical and/or mental defects and educational deficiencies. Selective Service advocated national prehabilitation which succeeded in creating some mild interest in the problem and a response on the part of education in setting up the Victory Corps and State Programs for Physical Fitness.

(2) On October 16, 1941, the President outlined a rehabilitation program designed to fit some 200,000 rejectees for service. This failed to yield material results mainly because it coin-

cided with more imperative and greater demands—the immediate procurement of vastly greater manpower following the attack on Pearl Harbor.

(3) The President created the National Committee on Physical Fitness under the administrative control of the Federal Security Agency.

(4) This National Committee on Physical Fitness set up a special commission which drew up a program for physical fitness in industry.

(5) The National Committee on Physical Fitness assembled a national council of 100 distinguished citizens to advise them in the various fields of activity.

(6) The National Committee on Physical Fitness invited the wholehearted participation of medicine, which resulted in the creation of the Joint Committee on Physical Fitness with equal representation for medicine and the Committee on Physical Fitness of the Federal Security Agency. The responsibility is now a joint one.

(7) The Joint Committee convened the National Council in a two-day session in which were set up programs for work in various fields: Institution Groups—such as the church, Y.M. C.A., et cetera; Labor, Management, Schools and Colleges, State-Local Organizations, Medical Affiliates, and so on. These plans are under study; some have been ratified already and are now being carried out.

(8) The Joint Committee has set up a platform of seven objectives:

1. Help each American to learn physical fitness needs.
2. Protect against preventable defects.
3. Attend to correctable defects.
4. Know how to live healthfully.
5. Act to acquire physical fitness.
6. Set American standards of physical fitness at high levels.
7. Provide adequate means for physical development.

(9) The Joint Committee has determined the scope of its function and the proceedings and measures to be employed.

Scope.—A program of such import and breadth

must be carefully formulated and will be successful to the extent to which it can attract and hold the active interest and support of various individuals and agencies through which the program can be effected. The program should include the following:

1. The fullest use of every means of promotion and education.
2. The increased assumption of responsibility by schools and colleges.
3. The fullest development of responsibility on the part of national organizations and agencies. This would include such groups as management and labor, social and religious agencies, patriotic organizations, civic groups, and youth and sports organizations.
4. The increased assumption of responsibility on the part of Federal, State and local governments as a public necessity to take their proper place in providing easily accessible opportunities for the improvement of physical health.
5. The enlistment of the active support of organizations of professional workers interested in the development and maintenance of physical fitness.
6. The utilization of the resources of industries associated with the field of physical fitness.

Measures in physical fitness.—The following (measures in physical fitness) are directed toward these objectives:

1. Adequate health inventory and services for the correction of remediable defects.
2. Proper nutrition.
3. The practice of personal hygiene, particularly cleanliness, adequate daily recreation, exercise, rest and sleep.
4. Healthful living conditions.
5. Programs designed to develop strength, agility, skill and endurance.

(10) The Joint Committee has made initial contact with the Governor of each State and with the Commission here in the District of Columbia in an effort to set up the necessary machinery for adequate state programs.

(11) The National and Joint Committee and the National Council have awakened public interest and support—more than 400 national organizations are harnessing their resources in the common cause.

(12) The Joint Committee, representing the Committee on Physical Fitness of the Federal Security Agency, the educational system, medicine and dentistry, has decided to abandon the concept “the year of special emphasis on physical fitness” and to proceed on the basis of a permanent program to meet permanent needs.

(13) The Joint Committee is now engaged, through its associated industry groups, in setting up a suitable foundation to handle its finances and the dissemination of information regarding its activities.

(14) The Joint Committee has concluded that only programs that make a personal appeal to the individual can have any material success. Consequently the program must be made attractive to all individuals who are to participate. This is especially true as it applies to youth.

(15) Subcommittees are now actively at work in various fields exploring possibilities. Inventories and pilot tests are being set up in the effort to find the best methods of approach.

GOVERNMENT AND PHYSICAL FITNESS

This problem should not become solely the responsibility of the Federal Government, even though it is naturally a great concern to it whether or not its citizens are physically fit. This is a community problem in every community in the country. However, there are certain ways in which the Federal Government may help. But let us see why it should help. Physical fitness and individual health are the biologic basis of that “life, liberty and the pursuit of happiness” of which the Declaration of Independence speaks. It is an essential ingredient of the “common welfare” for which this Nation was constituted. To help these great social objectives, the Federal Government can do a number

of things. It can furnish leadership on a national scale. It can assist agencies by supervision and guidance, where its services are requested. It can help the constructive research so necessary for the program in industrial and in agricultural areas, in the public health field and in the military services. It can provide accurate information in digestible form. It must provide grants-in-aid both on the basis of what the wealthier communities pay, and inversely on the needs of the community which cannot support minimum programs of public health. These grants-in-aid should be used for specific objectives which research and investigation show are below national averages or have potentiality for injuring a region. These objectives will change periodically but conscientious effort to reach these goals with the help of grants-in-aid will progressively achieve minimum standards of physical fitness throughout the Nation. This at least is felt to be imperative in the public interest.

THE COMMUNITY, THE DOCTOR AND PHYSICAL FITNESS

The United States of America represents the wealthiest nation in the world. The wealth of the nation should insure the health of its people. Mortality statistics reveal a low death rate. As longevity increases, chronic diseases keep apace in national importance. This Nation needs a peoples' program of physical fitness by the people and for the people. Only by the concerted efforts of the home, the church, the school, the government, social agencies, and the professions of medicine and dentistry can an adequate program be devised. A national movement for physical fitness has been organized. For success all society must participate and above all the individual whose stake and responsibility is the greatest. But doctors particularly should be interested and concerned. They have the essen-

tial professional knowledge of public health, of preventive medicine, of remedial medicine. They have an intimate personal knowledge of individual health, disease, and community conditions leading to disease. They have the high professional responsibility of the great profession to which they belong and the personal responsibility of citizens in possession of knowledge necessary for a higher life in the community.

SET A REAL EXAMPLE IN WASHINGTON

It would be peculiarly fitting if the medical and dental professions of this Capital City of the Nation would demonstrate for the Nation what an alert community under competent and inspired medical leadership could do in the way of promoting physical fitness. You have resources in the way of medical schools, which are to be greatly developed according to recent announcement. You have in the Federal Department sources of willing coöperation. But the great reliance must be on your spirit and your leadership. The spirit of Hippocrates must become a living gospel. You must help explain to other community agencies the significance of physical fitness and the program of the Joint Committee on Physical Fitness. Particularly you must inspire allied professions—the general nurses, the public health nurses, the medical technicians, the medical and other social workers who look to you for leadership—with your own spirit of community service. You will have pride every time Washington, D. C., is pointed to as a demonstration of what can be done. You will have the satisfaction of the good citizen who helped. You will have the professional joy of having participated in the leadership and the inspiration without which nothing would have been accomplished and we would just be drifting. In this program the Joint Committee on Physical Fitness seeks your active participation.

PHYSICAL REHABILITATION OF VETERANS*†

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THE problem of rehabilitation of disabled veterans during this wartime period and in the postwar period to follow is a tremendous undertaking. Many plans for the rehabilitation of young veterans of World War II have been formulated and some are now in effect, but these plans chiefly concern vocational rehabilitation. In order to derive benefit from any one of these plans or to carry out suitable vocational guidance for the future, the disabled veteran must be fully rehabilitated both physically and mentally. When this physical progress has been completed the veteran is then ready to pursue a carefully selected program of vocational rehabilitation.

The Veterans Administration has many benefits available for World War II disabled veterans. When a veteran becomes disabled from a disease or injury a complete examination is made to determine the need for outpatient clinic treatment or hospitalization. If the veteran has a disability which was incurred or aggravated in line of duty in active service, he is entitled to outpatient clinic service as well as hospitalization. All veterans who served during this war are potentially entitled to hospitalization even though their disabilities have no relation to prior military or naval service, provided they were discharged or released from active service under conditions other than dishonorable.

In order to accommodate the large number of World War II veterans now being treated in our outpatient departments and hospitals, it has become necessary to add emergency beds over

the standard capacity in a number of our facilities. Also the outpatient activities have been increased to take care of the steady influx of World War II veterans applying for examination and treatment. The physical medicine departments have been enlarged and additional equipment has been added to take care of the increased patient load in both the out- and inpatient departments. And in this connection specific programs of physical treatments have been developed and are now being employed in the treatment of cases of spinal cord injury⁸ with paralysis and other severe orthopedic and neurologic cases. There has also been established in certain designated facilities a program of treatment for the administration of hydrotherapy, including mineral baths. We have now in operation a small unit designated for the exclusive treatment of selected cases of chronic arthritis by means of hydrotherapy, mineral baths, balneotherapy and heliotherapy, located at Saratoga Springs, New York. We have a program that has been developed in certain of our facilities for the treatment and management of amputation cases in veterans of World War II designated as Amputation Centers. These Centers are made available to render the following care and treatment for amputees: amputation surgical treatment, if indicated, for a proper weight-bearing stump; treatment by means of necessary physical measures for hardening and shrinking of amputation stumps and proper exercises for motion prior to fitting of an artificial limb; supplying and fitting of artificial limbs; and finally, training in the proper use of the fitted artificial limb. Also in this connection these Centers will be available to serve all amputees who develop problems of painful amputation

*Read at the Sixteenth Annual Scientific Assembly of the Society, October 7, 1944.

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stumps or adjust artificial limbs which have been supplied to them. These Centers will have a physician in charge who is thoroughly trained and competent to handle all necessary amputation surgery and trained in the fitting and adjustment of artificial limbs.

There are now 94 facilities equipped with adequate physical medicine departments and 2 regional office clinics equipped with physical therapy departments to render outpatient physical therapy treatments, all under the direct jurisdiction of the Veterans Administration. These facilities are divided into 3 groups, General Medical and Surgical, Neuropsychiatric and Tuberculosis. The Army Medical Corps, Navy and Army Air Corps, all have extensive Centers for reconditioning of their men who are convalescing from illness or injury. Their program stresses reconditioning, whereas the Veterans Administration program is set up to accomplish complete physical rehabilitation of the disabled veteran.

Hospital and clinic treatment is supplemented by physical therapy, occupational therapy, recreational therapy, physical exercises, entertainment and diversional activities, educational and library activities, all combined to promote and hasten full physical rehabilitation.

The physical medicine departments now in operation in all our facilities vary in size and equipment depending on the bed capacity and types of patients. In our general medical and surgical facilities, the set-up consists of a large treatment room which is well equipped with electrotherapy apparatus, lamps for thermal and light therapy, massage and exercise. Additional room is provided for actinotherapy (ultraviolet rays), local and general exposures; and other rooms are set up for suction and pressure therapy and machines for electrodiagnostic tests and other specialized treatments. The hydrotherapy section is separate, but usually adjacent, and is equipped with arm and leg hot whirlpool, paraffin, and sitz baths and hydrogalvanic arm and leg baths. In the hydrotherapy section

there are also electric light body cabinet baths for the warming and sweating effects and hydrothermostatic control tables for the application of needle shower baths and Scotch douche sprays which are used for tonic and stimulative effects.

In the tuberculosis facilities a similar but less extensive physical medicine department is set up; but hydrotherapy in all its forms is omitted while actinotherapy and heliotherapy are stressed, and more ultraviolet ray lamps are provided for bedside, ward and general use.

In the neuropsychiatric facilities, the physical medicine departments are the same as in the general medical and surgical facilities except that hydrotherapy is stressed and is administered on a much larger scale. Hydrotherapy is administered in these institutions in the forms of continuous tub baths, packs, shower baths, needle sprays, Scotch douche and arm and leg baths. In these facilities there are continuous bath and pack rooms available at all times for disturbed patients, but the physical medicine activities are divided as follows: The main department is in the continuous treatment building and smaller units are set up in each acute treatment building or in some nearby ward for the administration of tub and pack treatments.

All of our physical medicine departments are equipped with ample mobile equipment for bedside and ward work, because early application of physical measures is advocated, and as the patients' conditions progress they can be brought to the department. Physical medicine plays an important role in the treatment of many diseases and war injuries and is used on a large scale. The physical medicine departments are headed by a trained physician in charge designated as a Reconstruction Officer, with a thorough knowledge of all physical modalities including occupational therapy activities. The physical medicine department functions independently, and patients are referred from services of the hospital and from the outpatient clinic. All patients are referred for treatment by their ward physician on a physical therapy clinical record

form, which is reviewed, checked and initialed by the physician in charge of the department. When the patient has been examined and the physical treatment prescription has been completed, the patient is turned over to the chief physical therapy technician who sees that the specific type of treatment prescribed is carried out. The patient is then assigned to a well trained staff physical therapy technician for the administration of the treatment prescribed. All treatments given to patients are recorded on the physical therapy treatment form; the progress of the patient is also noted thereon, and when the patient is discharged this form becomes a permanent record in the clinical folder of the patient.

Physical measures are prescribed extensively in the treatment of bone and joint injuries, including fractures and dislocations, which are so prevalent in war injuries due to gunshot wounds, bursting shrapnel and other projectiles used in modern warfare. The most common complications seen in compound fractures and traumata of the bony framework are chronic osteomyelitis and infections of the soft tissues. In joint injuries there is usually considerable damage to the periarticular structures and intrinsic tissues. There is also damage to muscles, nerves and blood vessels with subsequent loss of function, peripheral paralysis and impaired circulation. Restoration of function is of paramount importance in the treatment of traumata of osseous structures in which physical measures are essential when used in conjunction with indicated orthopedic surgical procedures and necessary prosthetic appliances. The chief aim in the treatment of injuries is to prevent, minimize and overcome as much as possible structural deformities. The following outline of physical treatment is employed: Thermootherapy, utilizing infra-red and radiant light and heat lamps locally to the parts, is used for superficial warming and heating effects to induce hyperemia of the tissues involved. Where deep heating effects are desired, the modality of choice is short wave diathermy, and in some instances where prolonged and

milder deep heating effects are preferable, conventional or long wave diathermy is preferred. The deep heating effects give a profound hyperemia within the tissues, relaxes the tissues, relieves pain and thus promotes comfort. Following the local heating of the part, massage and graduated exercises are usually given in all types of injuries to bones, joints and soft parts where there is congestion, swelling and pain with limitation of motion. The effect of massage on the tissues is sedative and relaxing, relieves pain and stimulates the circulation. Corrective exercises and remedial gymnastics are valuable adjuncts in the treatment of joint defects due to sprains, synovitis and bursitis and traumatic conditions affecting the spinal vertebra such as the sacroiliac and lumbosacral articulations.

Mechanotherapy is valuable for muscular reëducation to develop strength and range of motion and also to increase mobility of joints that are muscle-bound or have restricted motion due to adhesions causing fibrous ankylosis.

The use of local ultraviolet irradiation is effective when there is tissue sepsis, unhealed wounds, ulcerations, and in some dermatologic conditions. It also gives impressive results when applied to sluggishly healing trophic and decubitus ulcerations, postoperative wounds and tuberculous ulcers of the mouth and tongue and nasopharyngeal regions. Ultraviolet rays when given in sufficiently strong doses have a very beneficial and almost specific effect in erysipelas and herpes zoster cases. Exposure to the affected areas with the surrounding healthy tissues protected is about 10 times the erythema dose, but this should be modified depending on the severity of the infection. The use of general ultraviolet irradiation and heliotherapy is advocated for pulmonary tuberculosis cases to build up their resistance and for tonic and supportive effects in the rundown, weak and anemic cases. Ultraviolet irradiations locally and generally are advocated in the treatment of tuberculous adenitis and in other extrapulmonary tuberculous infections.

The galvanic and faradic currents are used in making diagnostic tests of injured nerves to determine the reaction of degeneration or the existence of partial or complete peripheral palsy. The chemical properties of the galvanic current for ion-transfer are used in the treatment of adherent and painful scars. The negative pole of the galvanic current when applied to painful scars produces softening and disintegrating effects which relieve pain and improve circulation. Cases suffering from injuries around joints which become swollen, red and painful with varying degrees of periarticular arthritis that do not respond to the usual methods of treatment have been treated with relief of symptoms with mecholyl or histamine ion-transfer. A very simple method which has been used successfully to accomplish histamine ion-transfer is by the applying of Amydyl unction freely to the affected part and then passing through the positive pole of the galvanic current using the current that will be tolerated by the patient for 20 to 30 minutes. This form of treatment produces hyperemia which is maintained in and around the joint for several hours and reduces the swelling and materially lessens the pain about the joint structure.

The sinusoidal currents produce wave-like rhythmic contractions and are used extensively for relieving spastic musculature following injuries of all types. This form of treatment is also used to increase muscle tone in weak and flabby muscles and overcomes atrophy in muscles following prolonged immobilization and non-use.

Hydrotherapy locally is beneficial in the treatment of acute traumatic conditions of the upper and lower extremities by the submersion of the affected parts in a hot whirlpool arm or leg bath, usually at a temperature between 105°F. and 115°F. The nature of the cases benefited includes recent contusions, acute sprains, recent fractures, peripheral paralysis, peripheral circulatory disturbances and painful and swollen amputation stumps. This form of treatment

has a definite sedative effect on the parts, reduces swelling, improves the circulation and increases function. This application is usually followed by underwater massage and exercise to relieve stasis and assist local elimination and metabolism. The sitz bath, hot, neutral or cold, is utilized in many postoperative, rectal and perineal cases to assist healing and to relieve swelling, congestion and pain.

General hydrotherapy in the form of warm baths, needle sprays and Scotch douche is given for stimulating, sedative and eliminating effects, in many cases requiring tonic and upbuilding therapy and for those suffering from various types of war neuroses. Hydrotherapy in the form of sedative baths is used effectively in selected types of cases of chronic arthritis. Spa therapy is recommended and is being utilized effectively in the treatment of cases of rheumatoid arthritis in several of our facilities. The therapeutic program of the spa is built around natural agents and is recommended for more extensive use in our physical rehabilitation program.

Fever therapy is now being used in conjunction with chemotherapy in some of our facilities in the treatment of paresis and central nervous system lues. Fever therapy with temperatures averaging 106°F. is usually given in these types of cases. Fever therapy is also given to certain types of cases of infectious arthritis effectively, using temperatures not to exceed 102°F.

Electric shock therapy is being employed in neuropsychiatric facilities in combination with psychotherapy followed by reëducation in severe types of cases of war neuroses.

Suction and pressure therapy is valuable in the treatment of frostbite and acute arterial embolism and thrombosis. In selected cases of arteriosclerosis and thromboangiitis obliterans it has been found useful, in spite of the fact that the usefulness of such therapy has been largely discounted. Our observations have shown that in certain cases of arteriosclerosis and thromboangiitis obliterans there have been relief of sub-

jective symptoms, healing of ulcers and reappearance of healthy color and warmth to the treated extremities after suction and pressure therapy. The technic employed is in conjunction with thorough warming of the extremities by means of a warm whirlpool bath at a temperature of 105°F. or by means of radiant light and heat employed prior to the suction and pressure treatment. During the suction and pressure treatment the trunk of the patient is exposed to radiant light and heat energy to increase the circulation throughout the treatment. Cases treated by this technic have shown improvement sufficient to permit them to become ambulant, following months of confinement to bed or wheel chair. We have an exhibit which is being shown at this meeting with photographs of the cases and the results obtained from pressure and suction therapy in peripheral vascular diseases.

The following outline of treatment and management for cases of spinal cord injuries with paralysis, and cases suffering from hemiparesis and other severe orthopedic and neurologic conditions are included in this group. These types of cases are grouped as far as possible in designated facilities where individual and group therapy can be administered by the physical medicine department. This group of patients was carried through a well formulated and specific series of exercises for the development of the muscles of the upper extremities and trunk muscles. These patients showed a greater degree of regeneration of the muscle strength in the muscle groups, as the abdominal, shoulder girdle and all extensors. They were instructed carefully in all stages of exercise with the aid of mechanical appliances, in the art of proper walking with the aid of parallel bars and crutches. These exercises and instructions were combined throughout, beginning at the bedside and later in the physical medicine department with physical modalities, such as local heat, massage, graduated therapeutic exercises, galvanic and sinusoidal stimulation, including all the paralyzed muscles to reduce the muscle spasm in the spastic

cases and to tone up the muscles in the flaccid cases. In cases in which decubitus ulceration is present the treatment given is infra-red irradiation followed by local and general ultraviolet irradiation, with daily exposures.

During the entire course of treatment everything possible must be done in order to prevent boredom and weariness of these disabled and crippled patients to assist them in keeping up their morale.

The prescribing of suitable occupational therapy to keep the patient busy between treatment periods is essential in these cases; also diversional activities and entertainment should be furnished at specified times by the recreational department. The furnishing of interesting literature, books and magazines for reading by the librarian is necessary to keep these patients happy and contented.

These types of cases should be encouraged from the beginning to do things for themselves as much as possible for self reliance and independence, which are of prime importance in the task of restoring them to economic usefulness.

There are many cases suffering from war neuroses, and the treatment in these types of cases offers a problem in our physical rehabilitation program. The incidence of war neuroses is high among discharged veterans even though the excellent reconditioning programs now being carried out by the Medical Corps of the Army, Navy and Army Air Corps have been helpful in the treatment of this group of cases. The development of war neuroses is inevitable because modern warfare is intense and severe and there are many predisposing factors, mechanized fighting, bombing and shelling. The war neuroses cases should be given every therapeutic advantage in order to restore them to fitness.

Occupational therapy is an indispensable adjunct in our physical rehabilitation program and is carried out in all neuropsychiatric and tuberculosis facilities and in some of the larger general medical and surgical facilities. All occupational therapy work should be closely correlated with

physical medicine. This is especially necessary in the treatment program for the young disabled veterans of World War II who should be kept occupied by proper diversional activities as well as assignment of work in occupational therapy departments. In neuropsychiatric hospitals the occupational therapy department has been developed to attract the attention and enlist the coöperation of mentally ill patients, and there is no doubt that the employment of the various projects for mentally ill patients has been one of the most beneficial treatment measures. The outdoor activities, agriculture, horticulture, care of swine, poultry, etc. have been especially acceptable and helpful. The indoor activities are carried out in rooms set aside for metal work, woodwork, jewelry work, weaving, textiles and educational courses. In the tuberculosis hospitals and in some of the larger general medical and surgical hospitals there are rooms set aside for fabrication of arts and crafts and curative work shops. All of the occupational activities are prescribed in an effort to overcome physical handicaps. Occupational therapy activities should be arranged to be first given at the bedside for all bedridden patients and then later to be continued in the shops and designated rooms under the assistance and direction of well trained occupational therapy aides. Occupational therapy activities are prescribed by the physician in charge of the case and are supervised by a well trained physician who is designated as the "Reconstruction Officer."

When the disabled veteran has received and about completed the fullest possible physical and mental rehabilitation, he is then considered for suitable vocational rehabilitation. The Director of Vocational Rehabilitation has vocational officers and advisers on duty in some of our facilities and regional offices and in other designated places to interview all veterans, and if they are found eligible for vocational training, a proper vocational training program is arranged. The physical handicap of each veteran is noted and checked by a physician in order that the

veteran may pursue the type of vocational training that will be satisfactory. The proper vocational rehabilitation program is then put into effect and will assume the task of restoring the disabled veteran to economic usefulness.

"Rehabilitation" has been defined as the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable. Physical rehabilitation is the use of physical therapy, occupational therapy, recreational therapy and physical training to promote and hasten recovery from physical or mental illness or injury. Rehabilitation should be considered as a vital part of therapeutics and should be administered under the supervision of the patient's physician.

CONCLUSIONS

1. Physical medicine together with indicated medical, surgical and orthopedic treatment supplemented with occupational therapy, recreational therapy and physical therapeutic exercises when applied in the early stages of diseases or injuries seen among veterans of the armed forces has been invaluable in our program for physical and mental rehabilitation.

2. Physical measures are usually employed in combination with indicated chemotherapy and prosthesis in order to obtain the best end results.

3. Physical medicine has contributed much to the care and treatment of various types of conditions seen in veterans by decreasing their disabilities and restoring function to the maximum degree.

4. The systematic use of physical measures and other indicated types of therapy as outlined in the treatment of severely wounded veterans will materially shorten the period of hospital confinement.

5. In the treatment of bone and joint diseases and injuries physical forms of treatment including occupational therapy along the lines described aid in the restoration to normal or as nearly normal function as is possible.

6. Emphasis is always placed on the accuracy

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RECONDITIONING IN CIVILIAN HOSPITALS*

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BY DEFINITION reconditioning is the restoration of an individual to normal or as near normal as possible mentally, physically and emotionally. The term is sometimes used interchangeably with rehabilitation, but strictly speaking, rehabilitation is the restoration of an individual's earning power. In the Army particularly, this differentiation of terms is important because, although reconditioning is a function of the Army Medical Department, rehabilitation has been delegated by Congress to the United States Veterans Bureau.

The United States Army Medical Department has undertaken a large scale reconditioning program, the aim of which is to restore the soldier as soon as possible to duty in condition to perform his functions, and, if that is impossible, to restore him to civilian life prepared to make a useful and happy adjustment.

There were several reasons for the Army's wholehearted adoption of the reconditioning program. In the first place, it was the efficient and economical approach to a serious problem. It meant that less hospital beds would have to be constructed, that the hospitalization time of the individual soldier would be curtailed, and finally it was felt that the incidence of complications would be reduced. The Army had scraped the bottom of the manpower barrel. The rate of induction of civilians provided only sufficient men to make up for the normal attrition of a vast Army, therefore it was imperative to make the best use of those who were already inducted. One way of accomplishing that was to cut the hospitalization time of the sick soldier by speed-

ing his convalescence and consequently his return to duty. Finally, scientific evidence was accumulating to show that convalescence was the most neglected and most misunderstood phase of illness and that scientific advancement in this field was an urgent necessity.

Reconditioning, in the simplest terms, is the scientific organization of convalescence. It is as scientifically important in its way as the development of sulfonamide drugs and penicillin in theirs. The importance of reconditioning in military medicine will generally be readily conceded, but skepticism is often displayed concerning its place in civilian medical practice. The point is made that the sick or disabled soldier is retained in the hospital until such time as he is fit for duty, whereas in civilian life the hospital patient after a certain point of convalescence has been reached returns home and "rests" before returning to his normal activities. Let it be recalled, however, that the objective in military and civilian medical practice is the same, that is, the return of the disabled patient to his occupation as rapidly as possible in condition to perform his functions. The contention of this paper is that either civilian hospital facilities and personnel are not available or, if available, not properly utilized to secure the speediest and most successful convalescence of the sick or injured individual.

In the past the term convalescence has been interpreted to be practically synonymous with rest. Rest, however, in many instances means deterioration. Let us think back to the many cases we have all seen in which rest has contributed to the development of bone atrophy, physiologic dysfunctions, muscular wasting, and to the development of psychoneuroses. The

*Read at the Sixteenth Annual Scientific Assembly of the Society, October 7, 1944.

day has passed when the surgeon who has operated on a patient and removed the appendix loses all further interest in the patient and his convalescence. No more will we hear patients told: "Your stitches are out now, you can go home tomorrow or the day after. When you get home, take it easy for awhile, and when you feel strong enough go back to work." Statements such as these are offensive to the average patient because they minimize the importance of his illness and consequently the importance of himself.

On the other hand, it is equally harmful for the physician to say: "You were at death's door with your pneumonia attack. Your lungs need rest to heal and you won't be able to exercise or work for weeks." This approach tends to cause a fixation on an organ and makes the illness assume an importance out of all proportion to its physiologic value. Let us not in this period of convalescence impregnate the seed of a noxious weed which will develop in the fertility of the patient's mind and smother the plants of emotional and intellectual attainment which have been carefully nurtured through the years.

The inauguration of the reconditioning program was a constructive step in the direction of ascertaining the facts about convalescence and was a preliminary effort to solve some of its problems. Through a carefully designed reconditioning program, the waking hours of a patient in the hospital can be filled with mental and physical activities of a constructive and healthful nature.

The establishment of such a program will meet with some resistance. The old concept of the rest cure as propounded by Weir Mitchell and by his school of followers has become an inherent part of medical teaching. Rest naturally has its place in convalescence, but its proponents have gone to such extremes that in many instances more harm than good has resulted. A well rounded reconditioning program is a method of attaining by means of a scientifically planned

schedule a happy medium between the extreme of rest of mind and body which leads to deterioration and the extreme of activity which also leads to physical and mental damage.

A precise pattern for a model reconditioning program for all types of civilian hospitals is beyond the scope of this paper. Certain general principles of reconditioning will be pointed out and certain factors common to all civilian hospitals will be discussed. The type of hospital, whether public or private, general or specialized, is of great importance in program planning. Each particular type has its own specific problems. As the different features of a well balanced program are discussed it will be readily seen that the emphasis of certain portions of the program must be shifted to meet local conditions.

The first step in the organization of a reconditioning program in a hospital is the establishment of a reconditioning service which should be on an equal plane with other professional services. The director of this should be a medical man who has had training and experience in physical education and physical medicine, and has at least an intelligent interest in psychiatry. Needless to say, the greater the educational and cultural attainments of such an individual the greater will be his value to the hospital. Under his direction should be the physical medicine, the occupational therapy, and the social service departments of the hospital.

The question is frequently asked: When should reconditioning begin in the patient's hospital stay? Since its purpose is to speed hospitalization and to make it more pleasant and constructive, it begins immediately upon admission of the patient to the hospital. An interview with the patient on admission by a member of the reconditioning staff will immeasurably allay the patient's natural fears, will orientate him about hospital life, and will go a long way toward restoring the patient's confidence and ego which are often shattered by the realization of disease or injury. In this interview reconditioning should be explained to the patient as a form

of therapy, as much a part of his treatment as his operation or his medicine. The opportunities in mental and physical reconditioning available at the particular hospital should be discussed with the patient in order to discover his latent talents and interests and in order to arouse his enthusiasm about the whole program. This interview in itself demonstrates to the patient that there is no concern about his prognosis and that this period of hospitalization because of illness is regarded as a necessary lull in the ordinary routine of the patient's life which affords an opportunity for mental, physical and emotional stock taking. In other words, this is the opportunity everyone longs for, "to get away from it all." Instead of spending this time in morbid introspection it is to be devoted to wholesome, constructive and novel mental and physical experiences. The patient would be told that this interview will be discussed with his physician, and the actual scheduling of activities will depend entirely upon his physician's decisions as to his capability to participate.

For purposes of efficient management the patients should be divided into four categories: Class IV patients should be those confined to bed; Class III, those who have just been released from bed; Class II, patients who are about ready to be discharged from the hospital or who are prolonged ambulatory patients; Class I, patients who have been released from the hospital but who return daily to participate in the Class II program until finally discharged from medical care.

To be effective all these groups must have a compulsory, scheduled, full day's program. The only deviation allowed would be by order of the patient's physician. The fact that the patient is thus guided in his activities, but complete regimentation avoided by some choice of activities, is therapeutic in itself. It must be remembered that the patient upon entering a hospital is severed from many of his links with reality including family, job, and normal environment. Plus these anxieties he has possibly pain

and certainly uneasiness regarding his condition. This transference to capable hands of the responsibilities for the utilization of his waking hours is a forward step in the day-by-day psychotherapy which is essential if "hospitalitis" is to be avoided and invalidism held to a minimum.

The daily schedule for each group of patients would include calisthenics, remedial exercises when indicated, physical therapy when indicated, occupational therapy when indicated or when desired by the patient, orientation periods, educational periods, and rest periods. A daily well balanced schedule would be arranged for each patient by the reconditioning service after consultation with the patient's physicians and after the initial interview with the patient. As the patient's strength improved the patient's classification would be changed by his physician and a new schedule arranged by the reconditioning service. The beneficial effect both mentally and physically of a systematic approach to convalescence cannot be overemphasized.

Physical reconditioning in civilian hospitals must necessarily consist mainly of general calisthenics. The responsibility for the administration of these calisthenics should be assumed by the physical medicine department. The well staffed department should have men and women trained in physical education who will be qualified to give appropriate calisthenics to the Class III, II and I patients in groups. The calisthenics to be effective must be appropriately selected to affect the important muscle groups of the body and must utilize the "overload principle." This merely signifies that any exercise to secure effective results must be carried on until the muscle group is tired and that increase in exercise be secured daily by use of a cumulative count and by increasing the tempo of the cadence. In order to secure the maximum results from these exercises the leadership qualities of the instructor and the employment of interest stimulators such as music and competitive methods are essential.

When specific portions of the anatomy are affected by disease or injury, special remedial exercises should supplement the general calisthenics. These should be prescribed by the patient's physician but should be supervised by the physical education instructors.

Mental reconditioning is at least as important as physical reconditioning and is accomplished by the presentation of orientational, educational, and recreational features. In a hospital, orientation, education and recreation cannot and should not be sharply divided. All features presented to the patient should be of such interest and value that they combine all three.

Orientation in civilian hospitals should begin in the morning by distribution of newspapers to all patients with an attached sheet giving hospital news, public address system's program, and special events of the day at the hospital. This should be supplemented by news broadcasts during the day over a public address system.

A public address system properly managed is invaluable in mental reconditioning. A daily schedule with choice of two programs is highly desirable. Certain features, considered therapeutic in nature, such as news broadcasts and certain musical programs would be broadcast by both channels making participation in this feature compulsory. The value of music is well recognized, and the hospital public address system programs should be supplemented by the live appearances of volunteer guest musical artists.

In the hospital theater scheduled showings of newsreels, short subjects of educational nature and escapist films should be held. Those patients who are confined to bed should not miss the beneficial effects of motion pictures, and portable projectors should show 16 mm. editions of the *March of Time* and similar films in the wards. The value of these in diverting the patient's mind and in stimulating purposeful thinking cannot be denied. The very fact that these and other such features are presented in a hospital will change the present morbid, hushed

atmosphere into one of cheerfulness and gayety. The enactment of the patient's personal drama of illness will take place before a backdrop of healthy, buoyant life instead of the dark foreboding one of death. The emphasis in medical thinking will be changed from pathology to therapy and the patient will work hand in hand with the physician to achieve their joint goal, the patient's recovery.

A series of lectures by members of the staff on medical and medical-social subjects might be arranged. These talks should be followed by quiz sessions, and round-table discussions should be encouraged. Features of this type not only are mentally stimulating but are highly desirable in obtaining public coöperation in public health and preventive medicine projects.

The hospital should possess a good library, and mobile library carts should make this important educational and recreational feature available to all patients. It has been found in Army hospitals that Western and detective stories lead in popularity, but best sellers and more serious books should be available and the patients encouraged to use their spare time during hospitalization to good advantage. Looking back upon time spent in activities such as these cannot help but make the ex-patient feel that his hospital experience was an enriching and constructive one.

Last but far from least is personal service for the patient. The patient in the hospital should be divorced from as many of the problems and cares of his ordinary life as possible. During the initial interview the patient should be cautiously questioned about personal problems and later should be tactfully interviewed by a trained social worker. Aside from any specific good that may be accomplished by this approach the mental catharsis thus produced will be therapeutic in itself. It seems remarkable that in most hospitals social service is reserved for the charity patient while other patients whose social problems are often multiplied in ratio to their wealth are totally neglected. Probably the curricula of

medical social service schools will have to be somewhat altered to prepare individuals to competently enter this new field of scientific reconditioning.

Physical medicine is only beginning to come into its own. The Baruch Committee on Physical Medicine and other such groups are stimulating research and correlating scientific knowledge on this subject in order to get it firmly established as a fundamental tool of medical therapy. Too often physical medicine is looked upon as merely an orthopedic therapy aid and its role in other surgical, medical and mental conditions completely overlooked. This condition will only be corrected by improvement of instruction in physical medicine in medical schools. It suffices to state here that physical medicine is a most important section of reconditioning and a large percentage of patients in a general hospital would benefit by scientifically prescribed massage and the use of ultra-violet rays, infra-red rays, diathermy, whirlpool baths, faradic and galvanic stimulation, and other such measures. A most important feature of a physical therapy department should be the remedial gymnasium equipped with medicine balls, skipping ropes, weights, pulleys, shoulder wheels, horizontal ladders, rowing machines, Indian clubs and stall bars.

Occupational therapy has long been used in mental hospitals, but few general hospitals have established departments. The Army discovered how few trained workers were available in this field when efforts were made to staff all general hospitals. There are three main types of occupational therapy: diversional, functional and pre-vocational therapy. The average civilian general hospital would be concerned with only the first two. Occupational therapy work ordinarily should be a prescribed activity for specific types of patients, but when space and personnel are available other interested patients should be permitted to participate when their physicians consent. Activities found interesting and of definite therapeutic value to the patient are

woodworking, small metal work, ceramics, leather work, weaving, plastics and graphic arts.

Here is presented an example of a typical day's schedule for a patient who has had a normal temperature for three days following an average attack of pneumonia. The patient would rise, shower, and dress between 7:30 and 8:00. Breakfast would be served at 8:00. The period between 8:30 and 10:00 would be reserved for physician visits but would also furnish an opportunity for the patient to read the newspaper and to hear latest news bulletins and a light musical program over the public address system. Between 10:00 and 10:30 the patient would participate in group calisthenics in the remedial gymnasium. Between 10:30 and 11:30 the patient would attend newsreel and educational short subject motion pictures. The period between 11:30 and 12:00 noon would be used for a personal service interview, selection of a book at the library, or listening to a radio program. Lunch would occupy a half hour between 12:00 and 12:30. This would be followed by an hour's rest period. At 1:30 the patient would go to occupational therapy and stay until 2:30. Between 2:30 and 3:00 a trained social worker would interview the patient and afford him an opportunity to discuss any personal problems he desires. At 3:00 he would go to an entertainment type of motion picture of an escapist nature. From 4:30 until 5:00 a second group of calisthenics would be given. From 5:00 until 6:00 the patient would have a rest period. At 6:00 the patient would have supper. From 7:00 until 9:00 he would receive visitors, listen to the radio, or attend a concert. Of course, patients would be excused from these activities in order to keep professional appointments, and the individual schedule would have to be approved by the patient's physician. It cannot be overemphasized that reconditioning is a form of therapy and that it must be prescribed to meet the needs of the individual patient.

Many physicians may object that such a program will markedly increase the cost of hospitali-

zation. Evidence is accumulating to show that such a program curtails hospitalization time in the Army from 10 per cent to $33\frac{1}{3}$ per cent. If this estimate holds true even to some extent in civilian practice, this saving, plus the lowered incidence of complications and the shortened convalescence at home before resuming normal activities, will more than pay the additional cost.

If such a program is adopted, it means some physical changes will have to be made in most hospitals. It entails the construction of a theater or hall areas for physical therapy and occupational therapy, installation of a public address system, provision of an area suitable for a library, and office space for administration. Some modern hospitals undoubtedly will even have a swimming pool and a gymnasium. In planning a hospital suitable for a good reconditioning program it must be remembered that the hospital will be the reconditioning center for the community and that patients discharged from the hospital proper may still return daily for reconditioning until finally discharged by their physician.

Before any hospital would want to embark upon such a radical and ambitious course it would naturally want adequate evidence that this scientific organization of convalescence is beneficial to the patient both in time saved and in healthful results attained. Evidence is beginning to accumulate to prove that the United States Army Medical Department was justified in expending the money, time and personnel necessary to successfully carry out its vast reconditioning program. Unfortunately, due to security reasons, more detailed data regarding this Army program cannot be released at this time.

However, recent articles such as Harrison's¹ have aroused great interest; he states: "There is no proof that rest in bed carried out for many weeks after symptoms have disappeared is of value in the physical management of the patient with congestive failure, angina pectoris, or myocardial infarction." Powers² showed that early

postoperative activity in a variety of major surgical cases reduced hospital days from 16.1 to 10.3 and total convalescence from 10.3 weeks to 5.7 weeks. He also showed that in a group of 100 patients, those who had enjoyed early activity had a much smaller incidence of postoperative complications than those who had a more conventional type of convalescence.

Dock³ points out that "The physician must always consider complete bed rest as a highly unphysiologic and definitely hazardous form of therapy, to be ordered only for specific indications and discontinued as early as possible."

The abuse of rest in many types of orthopedic conditions has been demonstrated by Ghormley.⁴ Levine⁵ says, "Rest in bed, which has been the backbone of our treatment of heart failure, needs reconsideration in the light of some possible harmful effects."

Finally, Menninger⁶ states that "The abuse of rest as a treatment in psychiatric conditions represents a neglect or misunderstanding of the real pathologic conditioning of a neurotic patient under the guise of a treatment which is not only futile and expensive, but very often definitely harmful." He further states, "The problem is rather to discover what prodigious internal consumption and blockade of energy has occurred and how it can be diverted again to fruitful employment."

Is the establishment of a reconditioning program in civilian hospitals, as outlined, a visionary plan which is never destined to see the light of reality? The answer to that question probably depends largely upon public opinion. The impetus for a great many medical-social changes has to be furnished by public opinion. This can be understood when it is considered that most of them involve the expenditure of large amounts of money which must be approved by public agencies. However, to be successful such a program must also have the enthusiastic support of the medical profession. This will only be obtained when sufficient scientific data are assembled to

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AVIATION PREVENTIVE MEDICINE*

MAJOR GENERAL DAVID N. W. GRANT

The Air Surgeon, Army Air Forces

THE expectation that wartime development of aviation will lead to an age of global air traffic has a reasonable basis in the fact that, in a military sense, we have already achieved maturity in this respect. A by-product of this development has been the public prediction, at times rather unconsidered, that the airplane would greatly intensify the hazard of the international transmission of communicable diseases and their insect or animal vectors.

This is one phase of preventive medicine related to aviation medicine which I did not touch upon when I addressed this group nearly a year ago. At that time, I described the work of the Flight Surgeon as encompassing all ordinary aspects of military medicine plus the medical engineering of the human body for high-altitude flight.

The scope of the Army Air Forces Medical Service is so broad that the Flight Surgeon may be engaged in fields of interest which are not basically medical and at other times in medical problems which are not intrinsically aeronautical. Examples of the former are the providing of electrically heated gloves to prevent frostbite at high altitude or body armor to prevent flak wounds and, of the latter, the sanitation of an air base or the immunization of a squadron against a specific disease.

One of the many methods for the control of communicable diseases in which the Army is actively interested is international quarantine. Since the airplane is a potential means for the exchange of diseases among the several areas of the earth, the Army Air Forces is specifically concerned in this phase of preventive medicine.

At the request of The Surgeon General, a Flight Surgeon was delegated to represent the Army in the Interdepartmental Quarantine Commission set up in May 1943 by the Secretaries of War and Navy and the Administrator of the Federal Security Agency. This Commission was charged with the study of the problems of foreign quarantine in air, sea, and terrestrial travel, particularly as these problems bore upon military interest, and was asked to make recommendations toward more secure and effective safeguards. Medical officers of the Navy and of the United States Public Health Service completed the three-man Commission.

One result of the Commission's comprehensive investigation of quarantine laws and practices, both from the civilian and military standpoint, and from the viewpoint of the United States and foreign nations, has been the revision of the Army Air Forces regulation dealing with the quarantine of personnel, plants, animals and their products, and with the disinsectization of aircraft. All of these factors required consideration in order to eliminate reasonable possibility of the introduction of disease of human or of economic importance. In the new regulation, traditional international quarantine practice was revised by de-emphasis of the physical inspection of the travelers upon arrival for the detection of signs and symptoms of infection. On the other hand, predominant emphasis was placed upon the broader policy of immunization against disease carried out throughout the Army and upon the continuous medical supervision of persons traveling under military jurisdiction.

By international agreement, based upon medical experience, the quarantinable diseases are defined as cholera, plague, smallpox, louse-borne typhus and yellow fever. Military practice

*Read at the Luncheon of the Georgetown University Medical Alumni Association, held in conjunction with the Sixteenth Annual Scientific Assembly of the Society, October 6, 1944.

requires routine immunization for smallpox, and in addition, immunization for typhus, yellow fever, cholera, and even plague when significant exposure is anticipated. This practice and the protection afforded thereby is recognized in the revised regulation when it states, "Travel by aircraft under the jurisdiction of the Army will be contingent on the satisfaction of immunization requirements of the War or Navy Departments." It is thus obvious that all military travelers and all persons traveling by military aircraft are protected against those quarantinable diseases with which contact may be expected.

Quarantine has also concerned itself with the louse infestation of travelers, particularly with respect to typhus fever. In this regard, the regulation also makes travel on military aircraft contingent upon freedom from vermin and from quarantinable disease at the time of departure. It is anticipated that the continuous medical surveillance exercised over military personnel and over those traveling by a military aircraft will warrant certification as to these requirements without special or individual investigation at airports of arrival. These principles have been recognized by the U. S. Public Health Service in its approval of the Army Air Forces regulation.

To what extent these practices can be applied in civilian traffic remains to be seen. If broad immunization, as carried out in the armed forces, could be extended to civilian travelers so that they might have the same directional protection from quarantinable diseases as the American soldier, the general population would thereby profit from a wartime contribution to preventive medicine. Whether such travel immunization could best be achieved upon a compulsory or voluntary basis cannot be determined in this discussion. It would, however, certainly be advantageous for the medical profession to advocate the general adoption of these practices which have proved satisfactory even under the strain of military traffic.

Another result of the work on the Interdepartmental Quarantine Commission, along with that

of other organized public health agencies, has been the realistic evaluation of the danger of the introduction of exotic diseases into this country upon the return of several millions of military personnel from overseas. Detailed consideration of this problem with respect to the outstanding disease hazards will support great moderation of the excessively pessimistic viewpoint adopted by some in the past.

Smallpox is a disease by no means absent from this country, and certainly our armed forces have a far greater protection against it than does the civilian population. This is shown by the infrequent occurrence of this disease in the military forces in contrast with the many hundreds of cases occurring yearly in our civilian population.

Cholera, to which exposure may be anticipated when our troops enter the endemic areas of the Philippine Islands, China, India, and other areas of the Far East, would probably not become an epidemic in the United States even if our troops did not have the protection offered by inoculation. This country is protected to an effective degree by widespread water purification, adequate disposal of sewage, and the fact that raw human excreta is not used as fertilizer.

Bubonic and pneumonic plague will be encountered, particularly in certain foreign seaports. But its spread to the United States or along channels of military communication must largely depend upon shipping, and not many of the infected rodents may be expected to wriggle through the shipping barriers erected against them. Certainly they present no airborne problem. Airports are essentially unattractive to rats in comparison with seaports, and the rat has little opportunity to board aircraft. In the many thousands of sanitary inspections performed on aircraft all over the world, less than 10 authenticated instances of rats on aircrafts could be discovered by the Interdepartmental Quarantine Commission. The airborne stowaway rat would have difficulty in nesting and multiplying for lack of suitable protection and food. As for human carriers, in addition to the protection

provided by plague vaccination, it must be recognized that danger of spread from man to man is practically limited to the pneumonic form of the disease, that this form of disease is rare, and that possible contacts with pneumonic plague will not be transported by aircraft under the jurisdiction of the Army within 7 days of their last possible exposure.

Louse-borne typhus is found principally in the cold climates of the world and may be encountered by military personnel, particularly in Europe and North Africa. Immunization against typhus is supplemented by that very effective synthetic insecticide, DDT, which has been extensively investigated, developed, and adopted during the present war for the effective delousing of individuals and for the protection of their clothing. With the aid of periodic medical inspections, the problem of typhus may indeed be expected to be minimal.

Yellow fever, endemic areas of which exist at the present time only in South America and South Africa, yields to immunization so completely that probably no more than a single case has been reported where the disease may have been acquired after inoculation. Death in this instance occurred on the fifth day following inoculation. As for its mosquito vector, in more than 40,000 examinations of aircraft all over the world the Interdepartmental Quarantine Commission was able to find record of the recovery of only 9 of these mosquitoes, and all of these were dead, save 1. During the present war the Army Air Forces have adopted the aerosol-pyrethrum bomb for aircraft disinsectization. The Air Forces regulation has standardized spraying to the moment before take-off of the aircraft in international flight from dangerous areas. Spraying is done with the plane fully loaded and all cabin openings closed until the plane is airborne.

By national regulation in the United States leprosy is also a quarantinable disease, but leprosy is already encountered in this country. It has been estimated that 2,000 American cases exist, of which perhaps a fourth are isolated in the

Federal leper colony at Carville, Louisiana. The long and intimate exposure usually considered necessary for the transmission of leprosy renders it a disease of probably no quarantine importance in military traffic.

A number of soldiers have acquired filariasis in the tropics, and it has been suggested that some of these may provide the source of infection for American mosquitoes. The history of this country suggests that the hazard of spreading filariasis in this manner may not be great. Thus Negro slaves in the last century constituted a large focus of filariasis, but even before the general appreciation of mosquito control in this country, this disease did not become endemic except in the region of Charleston, South Carolina. It is not likely that the density of the slave population in the old South will be approached by returning military personnel.

Malaria carriers may be expected among soldiers returning from the tropics, but this fact will introduce a problem not so new as it might at first appear. Malaria already exists in the United States where proper vectors have been able to thrive, and in previous wars, particularly in the War between the States, the Spanish-American War and the Mexican Campaign, large numbers of infected soldiers returned to homes all over the country. Transient foci of malaria at times appeared, but the disease did not become of great importance even in days before extensive mosquito control, land drainage, and screening had been adopted. By intensified preventive, protective, and suppressive measures, the Army has been able to reduce the incidence of this disease in highly malarious theaters of operations as much as two thirds to three quarters since early in the war. All returnees from overseas are subjected to a medical evaluation of the diseases to which they may have been exposed and pertinent physical and laboratory examinations are performed, including malaria smears when indicated. In general, the rate of secondary infection from malaria-infected returnees will depend upon the control of *Anopheles*

mosquitoes in the areas of their residence. It is not of course anticipated that military personnel will be returned to civil life with known active malaria.

The hazard in air traffic with respect to malaria lies in the possible implantation of types of malarial vectors more virulent and harder to control than those already existing in the area. The routine disinsectization of aircraft and the even more important mosquito control measures carried out about airports militate against this danger.

In the recent tendency of some health authorities to view the airplane with alarm as a carrier of international disease, one significant point has commonly been overlooked in the opinion of the members of the Interdepartmental Quarantine Commission. This is the fact that all known implantations of insects to date have been effected by surface vessels, trains and automobiles. It is not to be implied that the airplane is vector-proof without safeguards, but it may be pointed out that little or no attention has been given to the potentially greater problem of stowaway insects on surface vessels, trains and automobiles. The Commission found no known instance of a foreign vector of disease having been established in another country as a result of air transportation in spite of the tremendous increase of international traffic of military aircraft. This expansion has been of such proportions that the total air travel may not be expected to reach the present volume of military traffic for many years after the war. In any event, the safety factor of dilution will add additional protection in air travel just as it has prevented surface vessels and vehicles from becoming important links in

the chain of epidemic disease in recent years.

The general dimensions of the problem of human quarantine arising from expanded international air traffic may be judged from the experience of the U. S. Public Health Service. Covering all methods of transportation, its officers in the last 20 years have intercepted at the borders of this country 128 cases of quarantinable diseases. Only 13 occurred in the last 10 years. Of these numbers, something more than half were smallpox. Furthermore, the Commission was able to find only 1 instance in which quarantinable disease was known to have been transported by international air traffic. This was the case of smallpox flown to the United States from South America last spring. Thanks to immunization requirements and to constant medical surveillance, no case of quarantinable disease has been reported in military personnel crossing our international boundaries.

Thus we see that critical examination of available data, far from indicating that the airplane has increased the public health problem of quarantine, suggests that advancement lies along those lines clearly indicated in military practice: (1) the uniform control of insect vectors in all international transportation; (2) insect control programs about ports and airports of departure and arrival; (3) a broad policy of uniform requirement for immunization of the traveler in anticipation of the diseases to be encountered; (4) a realistic medical surveillance of the international traffic. Proper concept and efficient employment of these principles will provide a broader and more effective protection to the public health without interference or inconvenience in international traffic.

President's Page

THE BORDERLINE DISPUTE

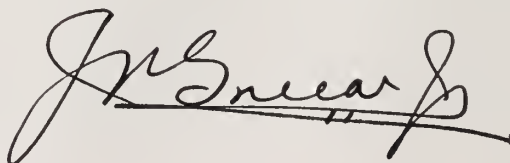
The Medical Society's Executive Board has followed with growing concern differences which have arisen between the Commission on Licensure for the District of Columbia and the Maryland State Board of Medical Examiners over the granting of borderline certificates. Its position has been that no change should be made in the midst of a war, especially when there is an acute shortage of physicians in nearby Maryland and Virginia within the Washington Metropolitan Area.

Early last summer, Dr. George C. Ruhland, Secretary of the Commission, informed the Society that the Maryland Board had notified him that in its opinion its regulations dealing with borderline certificates should be changed because "the population of the District of Columbia has extended well into Maryland, and in addition, there are now two hospitals recently built, one in Montgomery County and the other in Prince Georges County." Among the regulations proposed was one that would restrict the holders of borderline certificates to licentiates in the District of Columbia who visit occasional patients over the borderline into Maryland, "we'll say three or four a year." The Society's Board promptly registered its disapproval and the Commission concurred.

Nothing was heard of the matter again until in the latter part of October when the Maryland Board announced it was discontinuing the issuance of borderline certificates on November 1, 1944, but that those issued prior to that date would remain in effect, at least temporarily. Again the Commission and the Society protested the action taken by the Maryland Board as being unjustified and unwarranted under wartime conditions. The Maryland Board gave no indication that it would modify its stand.

The Commission on Licensure for the District of Columbia held a meeting on December 11 at which time the Maryland Board's recent action was considered. Prior to this meeting it had been suggested to Dr. Ruhland that the boundaries of the Metropolitan Area be defined and an attempt be made to agree upon a permanent reciprocal arrangement such as that which has heretofore existed. However, the Commission decided not to advance such a proposal. It was content to retaliate by discontinuing the issuing of borderline certificates to Maryland physicians as of November 1.

A serious mistake has been made by the Maryland Board. If its decision holds, every physician will be penalized for practicing in the District. It will only be a matter of time when physicians practicing in Washington will have to hold licenses in the District of Columbia, Maryland and Virginia. Such a denouement cannot be justified and the Society should make every effort to prevent it.



J. S. Sweeney

Editorials

THE YEAR OF DECISION

At the beginning of 1945, the medical picture is somewhat confused. However, one thing is apparent, that is, that important decisions in regard to the health of the Nation will probably be made this year. A new Congress will shortly be in session and it is understood that social legislation will have priority on its calendar. In view of the complexion of this body, this takes on added significance.

The question arises as to what the medical profession has done and is prepared to do about this situation. Some time ago a Government official talked to a group of medical leaders. There was some discussion about medical care and legislation which has been introduced in Congress. The official proposed that physicians introduce a bill embodying their conception of a health program. He referred to such legislation as an "antidote" to undesirable legislative proposals. This was sound enough advice except for one thing. If the medical profession's only purpose is to offer an "antidote," it does not deserve public confidence or support. For, as every physician knows, there are unmet health needs and these must be adequately provided for. To this end physicians should sponsor a national health program. Leadership should be given such an undertaking on a national level.

The question arises, is organized medicine prepared to advance a program in which it really believes? For example, too many physicians still look upon voluntary insurance plans as an "antidote" and no more. The blunt fact is that they are still skeptical of change. Unless these physicians, some of whom have been entrusted with leadership, are convinced that a well planned effort is necessary, it will be hard going

for the medical profession in the coming year.

Words must now be replaced with action. Unless it is forthcoming very shortly, prospects for the future will not be particularly bright. Principles and platforms have their value but they must eventually be translated into something tangible.

The Council on Medical Service and Public Relations of the American Medical Association held a three-day meeting at the Mayflower Hotel, Washington, on December 4, 5 and 6. On the last day of its meeting, the Council sponsored a regional conference. In attendance were representatives of state medical associations in Connecticut, New York, Delaware, Maryland, Virginia, Pennsylvania and the District of Columbia. One of the purposes of this conference, as stated in the agenda, was to discuss voluntary sickness insurance.

Prior to this session the Council announced that it has adopted the following plan:

"1. Continued expansion of the practice of medicine with full development of approved voluntary hospital, medical indemnity, industrial and commercial insurance against the costs of medical care."

"2. Development of public health facilities for preventive medicine all over the country."

"3. Development of adequate diagnostic facilities everywhere."

"4. The use of the voluntary insurance principle in caring for the indigent and medically indigent."

"5. The development of hospital facilities where present facilities are used to the utmost and are still inadequate."

"6. The use of federal funds to aid com-

munities in public health measures, care of the indigent and construction of necessary hospitals, when local communities are unable to finance the projects, but with retention of local administration."

"7. The creation of a unified Federal Department of Health, as above outlined."

In regard to prepayment medical plans, there was considerable difference of opinion among the participants in the conference. In fact, the respective merits of medical indemnity and medical service plans were the source of heated debate.

One could not help but reflect that this was indeed a healthy indication, coming though it does at a late date. Organized medicine should have been at this stage in the development of prepayment medical plans two or three years ago. Despite this, the interest shown was most

encouraging. Dr. John H. Fitzgibbon, Chairman of the Council, announced that another conference on prepayment plans would be held under the Council's auspices at Chicago in February.

It is to be hoped that the Council will not be diverted from carrying out the program it has outlined. So far it is of a general nature and it remains for the Council to be more specific. Upon the success of the Council's efforts will depend to a great extent the turn of events in 1945. Health legislation will undoubtedly be introduced in this Congress with greater public appeal than in the past. Unless the Council measures up to its opportunities, physicians of this country will have lost another round in their battle to serve the people adequately and maintain a high standard of medical practice.

PROBLEMS IN PENICILLIN THERAPY

In using penicillin for the treatment of infections susceptible to its action, the main intention is to keep adequate amounts of the drug continuously in contact with the infecting organisms. Aside from the nature of the infecting agent, there are a number of factors which influence the efficiency with which this object is accomplished.

The location of the infection in the body and the type of pathologic change it has induced are important.¹ Both of these factors may largely control the amount of penicillin administered as well as the route of administration. For example, when the infection is in a location which is naturally avascular or which has been made so as a result of the disease, ordinary methods of administering penicillin may be ineffectual. The same is true when the infection involves a body cavity into which relatively small amounts of penicillin are normally secreted from amounts available in the blood.² The joints and the

cerebrospinal system are examples of body cavities in which the concentration of penicillin normally is low following parenteral administration. It has been felt, therefore, that pyogenic infections in these areas must be treated by instilling penicillin directly into them. More recently, however, it has been shown³ that this is not necessarily so in the case of meningitis. Apparently, larger amounts of penicillin are extravasated into the cerebrospinal fluid of patients with meningitis than could be expected from studies on normal persons.

The amount of penicillin employed and the rapidity with which it is administered by some effective route necessarily control the quantity which is available for action against an infection. In the case of most infections the blood level of the drug is a guide to what we may expect of it in the way of useful action. Although the optimal concentration of penicillin in the plasma and tissues for the treatment of various in-

¹ Struble, G. C., and Bellows, J. G.: *J. A. M. A.*, 1944, 125, 685.

² Rammelkamp, C. H., and Keefer, C. S.: *J. Clin. Investigation*, 1943, 22, 425.

³ Rosenberg, D. H., and Sylvester, J. C.: *Science*, 1944, 100, 132.

fections has not yet been determined, it is probable that a blood level of 0.20 to 0.30 units per c.c. is adequate to control severe staphylococcal infections and 0.05 to 0.10 units per c.c. is sufficient for infection caused by the other susceptible pyogenic cocci.⁴

Maintenance of an effective blood level depends of course upon the amount of penicillin administered but also to a surprising degree upon the route and method of administration. Apart from the use of the drug by topical application and by instillation into body cavities, the route of administration must be parenteral. Theoretically the best method is by continuous intravenous drip, but technical difficulties have precluded uniform popularity for this method. In most instances at present penicillin is being given by intramuscular infusion, either continuous or interrupted. Somewhat larger amounts are required in order to achieve effective blood levels than when the intravenous route is used. Furthermore, it is well to remember that when the drug is given intramuscularly by the interrupted technic, an interval longer than 2 hours between injections greatly increases the amount of penicillin needed.⁵ For example, when the interval between doses is lengthened to 4 hours instead of 2, about ten times as much penicillin is needed for maintenance of similar blood levels.

One factor which greatly impairs the efficiency of action of penicillin is the rapidity with which it leaves the body. It is excreted almost totally by the renal tubules,⁴ and this takes place so rapidly that about 60 per cent of an amount given by vein can be recovered in the urine excreted during the ensuing hour.² Obviously any method which would delay this rapid loss would greatly improve our present technics and would result in a tremendous saving of penicillin. With this in mind various methods have been tried. The idea of delaying excretion by

withholding liquid so that the urinary output is curtailed has been considered. It is at once apparent that this is not a safe procedure in many cases, either because the illness is one in which a large liquid intake is desirable or because sulfonamides are being used coincidentally. A very logical approach to this problem of delaying excretion has been the administration of some other substance which is also excreted rapidly by the renal tubules. The competition of the other substance with penicillin for tubular excretion theoretically may be expected to furnish a kind of "renal blockade" for the penicillin. Rammekamp and Bradley⁶ have reported on the use of diodrast for this purpose. More recently Beyer et al⁷ have submitted para-aminohippuric acid to a similar trial in 9 patients. The competing substance was given intravenously at the same time as penicillin. There were no important ill effects, and the authors concluded that the method effects a considerable economy of penicillin or maintains blood levels not heretofore practicable.

Another method of prolonging the effect of penicillin given intramuscularly has lately been reported by Romansky and Rittman.⁸ These investigators have administered a mixture of penicillin and beeswax in peanut oil. This mixture is satisfactorily stable. A single intramuscular injection has been found to provide effective blood levels for as long as 6 to 7 hours, in contrast to the maintenance of adequate levels for only 2 hours after injection of penicillin in saline. No greater discomfort than usual follows the intramuscular injection of the beeswax-penicillin mixture. A single injection of the mixture containing 100,000 units of penicillin proved effective in curing 11 out of 12 cases of gonorrhea.

It is quite apparent that there can be no com-

⁴ Rantz, L. A., and Kirby, W. M. M.: *J. Clin. Investigation*, 1944, **23**, 789.

⁵ McAdam, I. W. J., Duguid, J. P., and Challinor, S. W.: *Lancet*, 1944, **2**, 336.

⁶ Rammekamp, C. H., and Bradley, S. E.: *Proc. Soc. Exper. Biol. and Med.*, 1943, **53**, 30.

⁷ Beyer, K. H., Flippin, H., Verwey, W. F., and Woodward, R.: *J. A. M. A.*, 1944, **126**, 1007.

⁸ Romansky, M. J., and Rittman, G. E.: *Science*, 1944, **100**, 196.

plete agreement yet as to the most efficient method for using penicillin. Rapid progress is being made in refinement of present technics, and entirely new technics are to be expected. Con-

siderable economy as well as an increase of effectiveness of the drug will naturally result.

H. H. H.

HABEAS CORPUS

Recent happenings reported in the local daily press bring into prominence one of those mysterious and mouth-filling phrases in which the law abounds—habeas corpus. The writ, one of the ancient procedures of the law, grew out of Magna Carta, and is designed to prevent illegal imprisonment of whatever sort by making it subject to judicial inquiry. It is thus applicable to prisoners confined in jails or prisons, to mental patients committed to institutions, or even to a case in which one might be deprived of liberty in his or someone else's house. One group, that of committed mental patients, may be examined somewhat more closely here.

In the several states one is sent to mental institutions, public or private, by legal processes. In the better organized states the private institutions are licensed and subject to inspection, including the investigation by the administrative authorities of the propriety of the admission and detention of patients. This group is small, in any event, only about 2 or 3 per cent of the total number of patients being cared for in private mental hospitals. The public hospitals (Federal, including Veterans Hospitals, or State or County or City) care for nearly all the mental patients of the country. They are, almost without exception, crowded, some of them very seriously, and in addition they are all, just now at least, suffering from shortages of personnel. Furthermore, each hospital administrator is desirous of vying successfully with his fellow administrators in establishing a good discharge record. For these reasons alone, all of which are quite secondary to the physician's desire to restore his patient to health, every public mental hospital is under

constant pressure to release those patients who have even a moderately good prospect of readjustment to the demands of life in the community.

A public institution of this sort, however, has a further obligation—that to retain under supervision those patients who by reason of mental illness might be dangerous to themselves (suicidal) or others (assaultive and possibly even homicidal). These patients do not constitute a large group in any hospital, but some of them are highly litigious and vocal. It is this group who file petitions for writs of habeas corpus, and undismayed by denial, repeat the performance as often as the court will permit. That persistence is sometimes rewarded is shown by the fact that cases are on record in the District of patients who have been released (without essential change in their mental condition) on the fourth, fifth or sixth attempt!

In a habeas case of the sort described, there are two issues: (1) Is the legal process under which the patient is held proper (that is, is he properly committed)? and (2) Is his mental condition such that his release would constitute a danger to himself or others? Such is the law, although of course the medical man is more interested in whether further hospital care would be beneficial to the patient. Presumably, under legal precedents, a judge needs some medical advice in the form of expert testimony in order to pass fairly upon the "sanity" of the patient. Fortunately, in the District the Commission on Mental Health, an agency appointed by the Court and therefore not only competent but neutral—assuming that the staff of a public hospital, as being parties to

the case, may be thought to be laboring under at least unconscious bias—is available. However, if the Court, acting under the suggestions of the Court of Appeals, utilizes the advisory services of the Commission, it seems reasonable to expect the judge to weigh carefully their report before rejecting it summarily.

Procedural reforms are always possible and sometimes helpful; in this instance there are procedural remedies which hopefully may be

invoked to remedy a situation which in the District (almost alone among the 49 jurisdictions of the country) has developed into a burden upon the Courts and institutions, to their mutual embarrassment and to the detriment of the institutional morale. Further than procedure, however, respect of the judiciary for the opinions of their own experts is needed if smooth functioning is to be looked for.

W. O.

In and Out of Focus

BY THE OBSERVER

Let's Get Acquainted What memories do you have of your grandfather? Perhaps you knew him as an elderly man, pleasant but rather remote, who was kind to you and the neighborhood children. But of your great grandfather, you have no recollection for he died about the time you were born. He is therefore only a name to you. In fact, as far as you are concerned, he might as well never have existed.

Let's reverse this picture. Contemplate your great grandchild, providing you have reason to believe that you will have one. Chances are that you will in no sense be a real person to him. Neither will most of the individuals whom you know and who seem so important in your daily life. Although it is highly improbable, one or two of your intimates may find a niche in history. Unless you are one of this select company, you will pass into oblivion even to your descendants.

So you see how unimportant you will be to people of tomorrow. In a sense that is to be expected, although your Observer, in common with others who have given this matter some thought, regrets that it is so, for it certainly is true we could profit a great deal if we knew our ancestors better. We would find among them

many worthwhile folks and knowing them we would understand ourselves better.

What has all this to do with medicine? Well, just this. At a meeting of the Society's Executive Board a few weeks ago, the Society was the recipient of a portrait of Dr. Joseph M. Toner, first President of the Columbia Historical Society and a former officer of the Medical Society of the District of Columbia. Your Observer wonders how many medical men in Washington have even heard of Dr. Toner. Board members, with one or two exceptions, did not even recognize the name. And yet Dr. Toner is probably one of the "greats" in Washington's medical history. In 1874 he was President of the American Medical Association. The same year he was also President of the American Public Health Association. He held many honorary degrees and memberships in scientific groups. He was a scholar and an authority on medical history in the District of Columbia. In 1882 he gave his library, including manuscripts, to the United States Government. It consisted of 28,000 books and 18,000 pamphlets.

There is much more of interest that could be written about Dr. Toner. But enough has been said to show that he was well worth knowing.

It was this discovery that prompted a proposal to the Editorial Board of the *MEDICAL ANNALS* that it run a series of "get-acquainted" biographical sketches together with the portraits of outstanding Washington physicians of the past. We should know them as intimately as possible for they helped make medicine what it is today.



An Indispensable Attribute Several years ago your Observer attended a conclave of medical students at a Midwestern medical school. Although the speaker's name escapes him, he has never forgotten his eloquence and sound advice to students. The true scientist, he said, is forever asking "Why?" He is never content with having learned superficial facts. He is constantly probing, seeking to unearth what has been hitherto unknown.

Curiosity is undoubtedly the indispensable attribute of the good physician. Is this attribute common among medical practitioners? The answer, in the opinion of this Observer, should be a qualified yes. It is certainly true that physicians are generally faithful in attending scientific meetings. If one looks into the programs which attract the largest numbers, one is not so impressed. The interest of many physicians, perhaps a majority, is limited to the "practical" aspects of medical science. New developments must be presented to them in such a manner as to have a utilitarian value; otherwise their attention wanders or they leave the meeting.

Most physicians, it would appear, are not students. They lack the "indispensable attribute" to a degree that does not do the profession credit. If the physician is to keep abreast of scientific progress, he must not only be willing to listen attentively to highly technical dissertations on research but he must devote a portion of his time to reading of medical literature. Only by this means will the physician grow in stature as a scientist and a practitioner of medicine.

"Medical Security Is... Coming" Readers of *Fortune Magazine* know what a thorough job of reporting this publication does. In fact, its treatment of a subject is sometimes so exhaustive the reader wearies before he is through. However, those who persist are usually well rewarded.

In the December issue of *Fortune* there appears an article entitled "U.S. Medical Transition," in which a searching analysis is made of trends in medical care. Included is an historical review in which organized medicine, its opinions and activities are not dealt with too gently. Plans of various sorts sponsored by physicians and others are described in considerable detail as are the provisions of the Wagner-Murray-Dingell Bill.

Fortune's viewpoint is best reflected in the following statement:

"The outlook for the extension of medical care, a definitely social need, is very bad if the structure and economics of medicine remain what they have been. There are, however, objective forces making for change, and one arises within medicine itself."

"... When the doctors now in uniform join the increasing numbers of progressive civilian doctors favorable to the new forms of practice, change will be hastened. When medicine is reconverted it will move ahead.

"Whether the change will come fast enough and prove effective enough to deflect the solution of the medical-care problem from the channels of federal legislation, is problematical. But it is just possible that voluntary coöperative action of U.S. employers, employees, municipalities, and other groups will largely solve the problem of medical care without federal legislation. The Committee on the Costs of Medical Care tried to draw the broad framework for a compromise plan. Such a plan would have to safeguard the quality of medical service and the personal relation between patient and physician, while assisting and guiding patients in selecting competent practitioners and suitable facilities. It would have to provide for the development of all preventive and therapeutic services to meet the needs (not just the present effective demands) of substantially all the population on financial terms that the people can and will meet, without undue hardship, through individual or collective resources. In order to permeate all practice with the concept of prevention it would have to provide an adequate public-health program. To individuals and agencies furnishing care it would have to guarantee adequate payment.

"No complicated, flexible, voluntary compromise between the status quo and state medicine will have a reasonable chance of growing to meet all unmet medical needs except under two general conditions. The first is that the country be prosperous, with reasonably full employment so that the bulk of the people are able to pay their own contributions without government help. Second, government at all levels, employers, the great mass of potential patients, and, above all, the medical profession must show a degree of social inventiveness and a determination hitherto unknown.

"If either of these conditions is absent, the U. S. is probably headed through a spotty and unsatisfactory experience with voluntary medical insurance toward compulsory nationwide insurance. Dr. Alan Gregg of the Rockefeller Foundation thinks that medicine may be in the state that education was in a hundred years ago—moving from a private to a public sphere. The analogy is too close for the comfort of those who want guarantees that medicine will not fall under the control of public servants, those who prefer voluntary methods, dispersed controls, and many minor forms of collectivism to one big collective step. The responsibility of the doctors takes the form of a dilemma that they must face: if they do not themselves aggressively foster and encourage considerable reform in medical economics, they are likely to find themselves swept into something that will seem revolutionary by comparison. By one means or another, medical security is undoubtedly coming. The consumers are making a social issue of it and it will, before too long, be met socially."



Medical Education in Britain In most respects, problems confronting the medical schools in wartime Britain are very much like those in the United States. For example, any student who has passed his examination in the preliminary sciences—chemistry, physics and biology—and has begun the study of anatomy and physiology has been exempted from the conscription in the armed forces and allowed to complete his training. The Government has appreciated the need for doctors not only during the war but afterwards and has made a careful selection of those who seem to have shown the greatest aptitude for the practice of medicine. However, there is one important difference between the training of

medical students in this country and in the British Isles. Our schools have been comparatively free of damage to their physical plants.

In an article appearing in the *Journal of the Association of American Medical Colleges* for November, Sir Arthur S. MacNalty, Editor-in-Chief of the British Official Medical History of the Present War, reveals the handicaps under which the schools are operating. He writes:

"The preclinical students of the London schools were removed to the provinces at the outbreak of war, and several of them became the guests of another university—Cambridge, Leeds or Birmingham—where they continued, as a rule, to be taught by their own professors and lecturers. Others,—for example St. Thomas's, Guy's and University College Medical Schools,—transferred to temporary quarters just outside London where country mansions, huts and converted buildings have been equipped from their own medical schools and residential quarters for staff and students have been provided. This adapted accommodation has served for the teaching of anatomy, physiology and pharmacology and also enables a certain amount of research (chiefly on war problems) to be done by the medical staff and senior students. The readiness of all concerned,—professors, lecturers and students, to improvise and make the best of things amid difficulties and discomforts,—as, for instance, in the adaptation of a stable or a tin shed for use as a dissecting room or a wooden hut to a physiological laboratory,—and the alacrity with which public schools gave the use of their science departments for premedical studies enabled the medical student to continue his education and provided a shining example of coöperative effort under war conditions.

"With the lull in air raids in 1941, several of the medical schools returned to London to teach preclinical subjects. Among these were King's College Medical Faculty, in association with Charing Cross, St. George's and Westminster, University College, the London Hospital, the Middlesex Hospital and the London School of Medicine for Women.

"Charing Cross Medical School was entirely transferred from London at the outbreak of war. A residential school was established at Chaulden House, Boxmoor in Hertfordshire, with the chief center of clinical instruction at the Emergency Medical Hospital at Ashridge. Now, except for the first six months of clinical study at Ashridge, Charing Cross students pursue the whole of their studies in London.

"All the other London hospitals continued to give some teaching in London in spite of severe damage from air

raids. The London Hospital still maintains its medical school in Whitechapel, but it makes use also of the E.M.S. Hospitals in the sector where at different periods of their studies students work under the supervision of members of the 'London' staff attached to these hospitals. This is an illustration of elastic organization of a medical school in time of war in relation to the Emergency Medical Hospital Service [a plan under which all hospitals, voluntary and municipal, are coördinated under a wide regional basis].

"The rest of the London hospitals, in spite of heavy air raids, have functioned as casualty clearing hospitals and teaching centers with some beds and outpatient departments. For other clinical instruction they have depended either upon that given at one or more of the larger E.M.S. Hospitals in their sector by their transferred staffs or have provided a special hospital in the country.

"As examples of the former arrangement, St. Bartholomew's, Westminster, University College, King's College, St. George's and the London (Royal Free Hospital) School of Medicine for Women, may be cited. The tendency has been for junior students to pursue their clinical studies in the E.M.S. Hospitals while the senior students do their work at the hospitals in London. The proportion of time spent in London has increased within the past two years of the war. Some hospitals, like St. Mary's and the Middlesex Hospital, have maintained the bulk of teaching in London with use, also, of the E.M.S. Hospitals in the sector.

"The latter arrangement is illustrated by St. Thomas's Hospital and Guy's Hospital, both of which have suffered grievously in air raids. In April, 1942, through the good offices of the Ministry of Health and the London County Council, a large hutted hospital was opened at Hydestile, Godalming, in the county of Surrey, as a country St. Thomas's Hospital. Visits are paid by members of the honorary staff. Parties of students attend for three-month periods at other E.M.S. Hospitals, where members of the honorary staff are also working. Students also attend a maternity hospital at Guildford in the same county.

"Guy's maintains a nucleus of teaching facilities in London. The first six months of the clinical period are spent at Pembury Hospital, Kent, and later years at Pembury, Farnborough and Guy's itself.

"The West London Hospital Medical School, which chiefly receives women students, has been little affected by the war, except for a diminution in its teaching staff.

"Thus by organization, adaptation, good-will and, above all, by the free use of facilities afforded by the Emergency Medical Service, local authorities and provincial voluntary hospitals, the students of the London

teaching schools have been enabled to supplement or replace the clinical instruction given at their own schools in wartime."

★

South Carolina's Ten Point Program On September 1, 1944, a Ten Point Program adopted by the South Carolina Medical Association became effective. A communication signed by Dr. Julian Price, Secretary of the Association, and M. L. Meadors, Executive Director of the Program, states: "There are two broad phases to this Program: (1) putting the specific parts of the Program into action, (2) educating our citizens as to what has been done and what we plan to do." Physicians were urged to become conversant with the Program, discussing it at every opportunity with patients, neighbors and public officials.

The Foreword in the pamphlet describing the Program reads in part as follows:

"In taking this step the Association was prompted by a feeling of social responsibility in the field of medical care and by the desire to take positive action in the promotion of continued mutual good-will between the profession and the public at large.

"The program is designed as a comprehensive long-range plan, and it will take time to accomplish all its objectives. It was adopted after careful study by the physicians themselves and after consultation with leaders in other fields of work. Experience may indicate changes which should be made and those in charge of its administration propose to keep their minds open to suggestion and constructive criticism."

The Points are as follows:

"1. Coöperation

To promote closer coöperation and better understanding between all groups and individuals concerned with providing and improving medical care for the people of South Carolina."

"2. Political Control

To prevent political control or domination of medical practice or of medical education."

"3. Study

To assemble and to amplify studies relative to the need and availability of medical care in each county of the state and in the state at large, and to publicize these findings."

"To study all agencies in the state which are involved in the administration of medical care as to the type of work which they are doing and the effectiveness of the work which is being done."

"To promote plans for providing or improving medical care where there is a need."

"4. Care of Indigent

To prepare a uniform plan for the hospital care of the indigent, financed by public county funds, which may be used by individual counties or by groups of counties for their indigent sick, and to promote the general adoption of such a plan."

"To promote the establishment of clinics in each county for the indigent ambulatory patients, financed by public county funds and operated or supervised by established hospitals or by the county medical society."

"5. Hospital Insurance

To make voluntary hospital insurance available to all the people of the state and to promote the widespread purchase of such insurance."

"6. Hospitals

To study the present availability and facilities of hospitals in the state and to promote the establishment of well-equipped and adequately-staffed hospitals in needy areas."

"To establish standards for hospitals in South Carolina and to make public the names of those hospitals which meet these standards."

"7. Group Health Insurance

To promote the establishment of group health insurance plans in all industries, large and small, in South Carolina."

"8. Standards for Insurance

To establish standards for insurance companies selling hospital or group health insurance in South Carolina and to publish the names of those who meet these standards."

"9. Medical and Nursing Education

To promote the securing of adequate funds and facilities for the operation of the Medical College of the State of South Carolina."

"To promote advancement in nursing education and nursing care in the state."

"To promote the establishment of a loan fund whereby worthy young men and women of the state who are financially unable to meet the strain of a medical education may be able to secure aid."

"10. Education of the Public

To acquaint the citizens of the state with regard to the agencies and facilities in the fields of medical care, public health, hospital and industrial insurance, and to encourage the people to use them on a much greater scale."

The above does not include some of the

descriptive material which was published in connection with each Point. However, the Points in themselves are sufficient to give readers of this column an idea of the extent of the South Carolina Medical Association's undertaking. If only a part of this program is realized, those who are responsible for it will deserve the greatest credit. Your Observer agrees that the medical societies must take the long-range view in their planning. What is most important now, however, is action—speedy action.



The Negative Attitude

Your Observer has no quarrel with any organization honestly seeking to better the lot of the medical profession. He may disagree with its methods, even with its objectives, but he feels that if they have merit they will survive. If not, they will fail. So why raise one's blood pressure?

A number of such groups have put in their appearance in the past year or two. This is rather surprising considering wartime prosperity and the fact that physicians have more than they can do. But perhaps this is the psychological time to warn the profession that dark days may be ahead. At any rate, at least three organizations are trying to convince physicians that they have their interests at heart and can best protect them.

Among these groups is the American Association of Physicians and Surgeons, originating in Gary, Indiana. As far as your Observer can recall, he has never commented on this organization. He does so now only because the motives of this group, sincere though they undoubtedly are, can only lead, in his opinion, to further difficulties for the medical profession. Any organization founded upon a negative attitude seldom wins public approval or support.

In a recent communication to physicians, the Association declared that the recent election has "swept away every hope that the free and

private practice of medicine will not be replaced by a system of state medicine unless physicians take immediate action to prevent that national catastrophe." It urges physicians to join the Association because only through this channel will physicians be able to withstand the onslaught of the forces which would regiment them. The Association proposes to combat legislation by requiring its members to "contract and agree with each other that they will not participate in schemes for the distribution of their services that are considered by the Association to be inimical to the public health." In response to the criticism of this threat to "strike," the Association counters with the statement that it will never strike against a patient but it refuses to be taken over by a Federal bureau.

In your Observer's opinion, the Association's logic is unsound. To begin with, if a Government system of medicine were an established fact, one can safely predict that there would not be too much difficulty securing the coöperation of a considerable number of physicians. Should many of them hold out, the public would resent their unwillingness to participate. Physicians would be expected to respect the laws of the land just as other citizens are required to do.

No, the solution to the medical profession's dilemma does not lie in negative action. If it wishes to establish itself in public confidence, it must offer an adequate national health program which it firmly believes to be better for the people than one which would regiment the public as well as the medical profession. To do otherwise is to court disaster.



Society's History Completed

After two years of research, Dr. John B. Nichols, Chairman of the Committee on History, has completed the task assigned him, that of writing the Society's history from the time of its organization to the present day.

Those who have been privileged to see the

manuscript which was turned over to the Executive Board at its meeting on November 27 have been highly pleased. They recognize Dr. Nichols' expertness in handling his material. He has not confined himself to relating facts in their chronological order but has dealt with certain phases of the Society's activities under the various chapter headings. The preparation of this volume has required months of careful study of minutes, letters, pamphlets, books, etc.

Which reminds your Observer that the Society has probably as complete a library devoted to the history of medicine in the District of Columbia as can be found in Washington. Largely due to Dr. Nichols' interest in the matter, books and pamphlets on the subject now have been gathered together and placed in one section of the Society's library.

Serving with Dr. Nichols on the Committee on History have been Dr. William J. Mallory and Dr. Joseph S. Wall. Both of these members have reviewed the manuscript submitted and given it high approval.

Lt. Colonel James N. Greear, the Society's President, writing Dr. Nichols, stated: "The Board has asked me to express to you and to the other members of the Committee its deep appreciation. . . . I personally want to say to you that few men in the history of our Society have rendered as outstanding service as you have. Many physicians have spoken to me about this, among them your contemporaries. They regard you most highly not only as a man of culture but as a physician who, in his more active days, stood second to none in his field."



Commercial Insurance

At a recent conference of the National Physicians Committee for the Extension of Medical Services held in New York, wider distribution of medical care was discussed. On the day following the conference, the *New York Times* editorialized as follows:

"The conference of the National Physicians Committee was purposely limited to commercial insurance, and this was held out as one effective way of forestalling governmental action. There is no reason why commercial insurance should not play its part in bringing good medicine to the people, provided that quality of medical care is stressed and provided that preventive medicine is assured. But the emphasis at the conference was all on existing forms of commercial insurance. With few exceptions these provide cash benefits, and then only for surgery and the hospital care. Little is done for the sick.

"Commercial insurance which fails to guarantee the best diagnostic service, an essential in preventive as well as creative medicine, and the best medical attention either in a physician's office or a hospital cannot stave off legislation. Nor can private practitioners benefit by the prevailing form of commercial insurance, since the cash benefits are not generally spent at present in curing sickness.

"The investigation conducted by the Public Opinion Research Corporation indicated that the public mind is confused. There is no popular agreement on the care of the sick and disabled at low cost. Whether or not that care should be entrusted to official, salaried doctors, insurance companies, group practitioners, hospitals or other organizations the public has not decided. The conference did not clarify this confusion. Not one spoke for the public or for the general practitioner. We were given no medical plan at all to contemplate as a solution of a vital problem that confronts the country."

Your Observer does not go along with the *Times'* argument for full coverage insurance. He believes that it would be far wiser to experiment with partial coverage, with full coverage as the eventual objective. A sound system of medical care cannot be developed over night, whether it is done by the Government or private enterprise. If the Government should try to do so, it would have a first-class headache on its hands.

There is one point on which this Observer does agree with the *Times* and that is that the existing forms of commercial insurance are not entirely satisfactory from the standpoint of the beneficiary. Certainly they are in no way a substitute for voluntary prepayment medical plans sponsored by the medical profession and other groups in the community.

This brings up a matter which has stirred up considerable discussion, that is, the respective merits of indemnity and medical service plans. Your Observer was privileged to listen in on a heated debate on this subject. When the air had cleared, it was quite apparent that all voluntary prepayment plans are a part indemnity and part service. One suspects that some physicians in high places favor indemnity plans because they feel that insurance companies will eventually take them over. This sort of thinking may lead to further difficulties for the medical profession. One thing is certain, commercial insurance "cannot stave off legislation," and it will not be accepted by the public in lieu of non-profit plans.



Why Graduates Avoid Rural Areas It has long been a source of concern to those interested in the Nation's health that the number of physicians seeking locations in rural communities has diminished to such an extent that certain areas have suffered for want of necessary medical service. Dr. I. H. Manning of Chapel Hill, North Carolina, comments on this situation in an article appearing in the October issue of the *North Carolina Medical Journal*.

"Let us accept as a fact that the rural population as a whole is not receiving adequate medical care. The usual explanation given is the scarcity of doctors in the rural sections. In many counties, however, wherein there are adequate hospital facilities and several if not many doctors, this explanation will not hold water. With the good roads throughout these counties the transportation time from any part of the county to a hospital is not more than an hour, and except in a small percentage of cases the immediate need is not so great that this time is a factor. If, therefore, the rural population in such counties is not receiving adequate medical service the explanation is not the scarcity of doctors, but is largely, if not wholly economic.

"In counties where adequate hospital facilities are not available and where there is an actual scarcity of doctors, the problem is again largely economic. Doctors cannot be expected to locate in any section in which they cannot

make a living. For this situation the only remedy is the subsidy. There are, however, other factors.

"The graduates of medical schools are thoroughly instructed and trained in the practice of scientific medicine which requires laboratory and hospital facilities, although not necessarily hospital accommodations. A section in which none of these essentials are available will not attract a young doctor who has had such training and who has some ambition, and it is safe to predict that few of our graduates will locate in rural sections under such conditions. The problem is to improve the conditions."

The Duke Foundation has been building hospitals in various counties of North Carolina for the purpose of attracting doctors to rural areas. These hospitals are maintained by the community except that the Foundation pays one dollar a day toward the care of charity patients. However, it appears that, despite the generosity of the Foundation, economic conditions have been such in some parts of the state as not to justify the erection of a hospital. Under such conditions, Dr. Manning makes the following suggestions:

"An alternative and less costly means of making practice in the rural sections more attractive is the establishment of a 'diagnostic laboratory,' which has been successfully tried out in Michigan as a project of the Kellogg Foundation. The laboratories are equipped to furnish at low cost such laboratory information as the doctor may desire. According to the published reports, such a laboratory may become self-supporting within eighteen months. Eventually it may become the nucleus of a hospital or at least a clinic. A laboratory may be set up in connection with the County Health Department for this purpose.

"The clinic seems to offer the most promising solution of the problem of making the rural sections more attractive to the doctors."

Dr. Manning points out that there are a number of such clinics operating in North Carolina, all of them privately owned and limiting their services to minor surgical operations and obstetrics. "Such clinics, if adequately equipped," Dr. Manning continues, "will answer the purposes of a general practitioner in a rural community. Unfortunately the young doctor, fresh from a hospital training and perhaps in debt for his education, cannot

afford a clinic; but if such a clinic is made available some of the recent graduates who prefer an independent practice and the opportunity to get quickly on their feet financially will accept the chance of a rural practice and later may take over the clinic as a private enterprise.

"To make this suggestion operative there is need for a revolving fund to finance the venture. This is a chance for some foundation to render a real service to the rural population.

"As the clinic does not provide for major surgical operations, and should not attempt to do so, the rural population must depend upon some hospital in near-by towns or cities, or upon a state supported general hospital as suggested by the Governor, where such work can be done safely. For these major hazards insurance is the only solution, and this can be brought within reach of the rural population through voluntary health insurance associations, which are designed for the protection of the low income groups and furnish the service at the lowest possible cost consistent with sound business."



Course in Medical Socioeconomics At its last session, the House of Delegates of the American Medical Association voted to instruct the Council on Medical Education and Hospitals to take necessary steps to have each approved medical school give an adequate course in medical socioeconomics.

There are several medical schools which have had such courses for a long time. Among these is the Georgetown University School of Medicine. This year the course to be given at Georgetown is being revised and expanded to include matter heretofore omitted. Subjects to be discussed are:

- The Doctor in Modern Society
- Continuation of Medical Education
- On Establishing a Practice
- Efficiency in the Doctor's Office
- The Doctor's Financial Records
- Proper Handling of Patients' Accounts and Doctors' Investments
- Relationship of the Private Practitioner to the Health Department
- Social Agencies and Their Relationship to Medicine

The Doctor's Role in Public Affairs
 Experiments in Medical Care
 Growth of Government Health Services
 The Future of Medical Practice

In addition to Theodore Wiprud, Professor of Medical Socioeconomics, the lecturers in this course are Drs. Arthur C. Christie, Frank D. Costenbader, O. B. Hunter, George C. Ruhland, R. C. Williams, Wallace M. Yater and Mr. Willard C. Smith.

So far, these courses have been in an experimental stage but they are emerging as an important and integral part of the curriculum of the medical school. It has long been a source of concern to many physicians that medical students have been permitted to graduate without any knowledge of the kind of world they must become a part of and how to approach and deal with non-scientific aspects of their profession.

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As is well known, a majority of the interns and residents, upon the completion of their hospital training, are at present inducted into the armed forces.

Literally thousands of them will therefore not engage in private practice until after the war. Naturally, they are much concerned as to what the future holds in store for them. Few have had any contact with medical organizations. It seems to your Observer that it is an obligation of medical societies to interest themselves in these young physicians and, where possible, accept them as members without dues for the duration.

Upon the recommendation of the Society's Committee on Rehabilitation of Service Physicians, the Executive Board, at a recent meeting, voted unanimously to instruct the Secretary to communicate with the physicians who had interned in Washington hospitals and who are

now with the armed forces. If they have been licensed to practice in the District of Columbia, they are qualified to become Active members of the Society. In this event, they will be invited to apply for membership and informed that they will not be obliged to pay dues until one year after they have returned to civilian life.

This action by the Board deserves commendation. Undoubtedly it will be welcomed by physicians in the services who intend to make Washington their home.

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Health and Accident Coverage for Physicians

For some months, the Society's Executive Board has been studying group health and accident insurance for physicians. It had about come to the conclusion that it would approve a policy submitted to it but would not officially endorse it. However, a member of the Society requested that the membership be canvassed to ascertain its views in regard to the matter. This was done with the following results.

On November 13, 323 physicians had responded, of which 287 were interested in securing this type of insurance, 3 were over the age limit, 3 already carried such insurance and 30 were not interested. Of the last group, several requested that further information regarding the proposed policy be provided them.

In view of the number who apparently are interested in this type of insurance, several policies are being investigated. Members should keep in mind that the Board has no interest in this matter except as it will benefit the Society's membership. Several insurance representatives have called at the Society's office, somewhat perturbed because physicians canvassed include clients who have bought individual policies or contemplate doing so. It has been explained to them that the final decision as regards a group policy rests with the membership.

MEDICAL BOWLING LEAGUE OFF TO A FLYING START

Entering its fifth season, the District of Columbia Medical Bowling League is off to a flying start with eight teams rolling every Friday night on the King Pin Alleys, Fourteenth Street and Rhode Island Avenue, N.E.

This year the League is headed by two of its most ardent bowlers, Major George A. Resta, President, and Dr. Millard F. Ottman, Vice President. Hard working officers, cigar smoking bowlers, if they can win a twenty-five cent wager from Colonel George Ball, another of the League's better bowlers, they are exceedingly happy.

The end of the first quarter finds Dr. Ottman's Suburbanites in a tie with Dr. G. H. McLain's Sibley No. 2 team, each with a standing of 13 won and 5 lost. Sibley No. 2 has been somewhat handicapped for several weeks due to the loss of their Captain, Dr. George McLain. The reports we hear are that he has a bone in his leg. Well, bone or no bone, we hope to see him back real soon. One of the first captains, Mack has put a good team in the League every year.

Tie for third place is Mt. Alto No. 2 and a new-



comer in the League this year, Pentagon, captained by Major A. J. Nicolette. We also have here a battle between the two team captains for high average of the League. Paul Duffy, Captain of Mt. Alto No. 2, is carrying an average of 117, with Major Nicolette running a close second with 115. Mt. Alto No. 1, captained by Lt. Colonel Frank Bacon, is in fifth place, one game in front of Dr. Wm. H. Clement's Sibley No. 1, in sixth place. Bill's team is just showing some signs of life after a slow start. Dr. Frank Richardson is pacing Sibley No. 2 team with a 110 average. Bringing up the rear are two new teams in the League, Columbia in seventh place, Captain J. E. Kadan, with Dr. Mann rendering yeoman service, and last but not least, with a fighting captain, Dr. W. R. Perkins, is Doctors Hospital, in eighth place.

Dr. Bill Lewis, tooth expert as well as bowler supreme, has high set of the League with 386. Paul Duffy has high game in the League with 145.

The League rolls four series and we have just completed the first. There are several places open on some of the teams, so come out and enjoy the fun.



PHYSICIANS OVER THE TOP IN WAR LOAN CAMPAIGN

Under the leadership of Dr. W. Calhoun Stirling, the Medical Division of the Sixth War Loan Campaign went over the top in flourishing style, as it has done in previous war finance campaigns. Latest reports at press time fixed the rising sales at \$1,110,000, or \$110,000 over the quota assigned to the 12 leading hospitals in the District.

In a glowing tribute to Dr. Stirling and his associates on the committee, W. J. Waller, Chairman of the D. C. War Finance Committee, complimented the group for an effective job done in spite of the handicaps the war effort has imposed on the medical profession.

"It was an encouraging sight to see your group

find the means to squeeze into your overcrowded daily schedules enough time to devote to the war finance program," Mr. Waller said, "and while the amount of bonds you have sold is impressive and most helpful, far more impressive is the fact that you were able to do it while continuing unabated your first duty to our community—that of ministering to the sick."

In a statement addressed to his associates on the committee and to the volunteers who worked under them, Dr. Stirling declared that the coöperation the group received was "superb and a model for others to copy."

(Continued on page 48)

AN ANALYSIS OF DEATHS REPORTED TO THE CORONER'S OFFICE

January 1 to October 31, 1944

A. MAGRUDER MACDONALD, M.D.

Coroner for the District of Columbia

The medical graduate upon entering practice is, in many respects, in much the same situation as an individual setting himself up in a business. He is beset with rules and regulations. Among other things he must obtain his state license, local license, narcotic license and, of course, he must apply for hospital privileges. He likewise must observe numerous regulations, mostly of a local nature relating to the reporting of communicable diseases, births and deaths. It is with the latter I, as Coroner for the District of Columbia, am especially concerned.

In the jurisdiction for which I am responsible, a physician may issue a death certificate in cases under his professional care when death is due to natural causes, providing he has been in attendance within a period of ten days prior to death and longer than twenty-four hours. Where death is due to other than natural causes, it is the Coroner's duty, as defined in the Code for the District of Columbia, to take over. Physicians recognize, but sometimes forget, that although such deaths may not be instantaneous the Coroner is required to investigate if they occur within a period of one year and one day. Under the law, an individual responsible for an act of violence can be held accountable even if the death is not the direct result but due to belated complications.

The Coroner's investigation may have extensive ramifications; it is his duty not only to determine the cause of death but to investigate the circumstances of an individual's demise. For example, a physician may be treating a patient suffering from burns. This individual may have received his injuries in any of several ways, such as falling asleep with a lighted cigarette, standing too close to a heater, using an improperly labeled heating compound, being on the receiving end of a thrown lighted lamp or heater or attempting self-destruction. There is a possibility, too, that his home or apartment accidentally caught fire and some one else is guilty of criminal negligence for failure to provide safety exits or appliances.

Indicative of the variety of circumstances which require investigation by the Coroner is the list of deaths referred to his office. The total number of deaths in the District of Columbia from January 1 through October 31, 1944 was 7,237 (figures obtained for publication through the courtesy of Dr. George C. Ruhland, Health Officer). Of this number, 3,711 deaths, or 37.3 per cent were reported to the Coroner's office.

There has been a gradual increase in the number of white cases over the colored. Anatomic material has naturally decreased due to social security, old age pension and to other reasons. There has been a marked decrease in suicides. Illuminating gas poisoning continues to be the chief means of self-destruction. There is a low abortion rate. This decline is due to the coöperation of the medical profession in reporting these cases when they come under their professional care so that they may be investigated prior to their death. There is no abortion "ring" in the District of Columbia and all known abortionists have been forced to fold up.

Coronary heart disease leads in the number of deaths from natural causes.

The following data are not only revealing but worthy of study:

STATISTICAL REPORT OF THE CORONER OF THE DISTRICT OF COLUMBIA

January 1, 1944 to October 31, 1944, Inclusive

	Va.	Md.	D.C.	Total
Total number of cases.....	18	40	2642	2700
Violent deaths.....	18	40	452	510
Abortions.....	—	2	7	9
Natural deaths.....	—	—	1810	1810
Stillbirths.....	—	—	380	380
Cases filed with District Attorney's Office.....	—	—	68	68
Number of autopsies.....	6	12	423	441
District deaths (figures obtained from Department of Health).....	—	—	7237	7237
Comparative percentage of Coroner's cases to total of District deaths.....	—	—		37.3%
Number of inquests.....	—	—	115	115

HOMICIDES

	Va.	Md.	D.C.	Total
Shooting.....	1	1	21	23
Stabbing.....	—	—	17	17
Assault.....	—	1	12	13
Strangulation.....	—	1	4	5
Abortions.....	—	—	4	4
Suffocation—fire.....	—	—	1	1
Poisoning.....	—	—	1	1
Submersion.....	—	—	1	1
Total.....	1	3	61	65

Number of autopsies..... 1 3 61 65

Note: The following are included in the above Homicide table:

Justifiable.....	—	—	9	9
By police officer in discharge of duty.....	—	—	2	2
Homicide & suicide combined.....	—	—	—	—

SUICIDES

Illuminating gas.....	—	—	38	38
Shooting.....	—	—	11	11
Hanging.....	—	—	8	8
Cutting.....	—	—	3	3
Submersion.....	—	—	7	7
Jumped from building.....	—	—	5	5
Jumped from bridge.....	—	—	5	5
Poisoning:				
Barbital.....	—	1	4	5
Sodium fluoride.....	—	—	3	3
Caustic poisoning.....	—	—	2	2
Nicotine.....	—	—	1	1
Total.....	—	1	87	88
Number of autopsies.....	—	1	15	16

HIGHWAY ACCIDENTS

Pedestrians and:				
Automobiles.....	4	6	24	34
Autotruck.....	1	—	9	10
Streetcars.....	—	—	16	16
Bus.....	—	—	4	4
Horse-drawn vehicle.....	—	—	1	1
Collisions:				
Autos.....	—	2	3	5
Auto and streetcar.....	—	—	2	2
Auto and bus.....	—	—	1	1
Auto and bicycle.....	—	—	1	1
Auto, pillar, post, tree.....	2	5	3	10
Auto, fence, wall.....	—	2	3	5
Auto and truck.....	—	1	2	3

HIGHWAY ACCIDENTS—Continued

	Va.	Md.	D.C.	Total
Motorcycle and post.....	—	1	—	1
Streetcar and bus.....	—	—	1	1
Total.....	7	17	70	94
Number of autopsies.....	2	3	70	75

FALLS

Window.....	—	1	8	9
Roof.....	—	—	4	4
Skylight.....	—	—	1	1
Stairs.....	—	—	12	12
Ladder.....	—	—	1	1
Street.....	—	—	10	10
Home.....	4	1	71	76
Train.....	—	1	1	2
Bicycle.....	—	—	1	1
Bed.....	—	1	6	7
Stairwell—banister.....	—	—	3	3
Bank, fence, railing.....	—	—	1	1
Platform—balcony—porch.....	—	1	1	2
Railroad viaduct.....	—	—	1	1
Total.....	4	5	121	130
Number of autopsies.....	—	2	33	35

MISCELLANEOUS CASUALTIES

Kicked by cow or horse.....	1	—	—	1
Diving.....	—	2	—	2
Injured while wrestling.....	1	—	—	1
Playing football.....	—	—	1	1
Struck by lightning.....	—	1	—	1
Aeroplane crash.....	—	2	3	5
Building construction.....	—	1	—	1
Buried in coal pocket.....	—	—	2	2
Explosion.....	1	—	—	1
Electricity.....	1	—	1	2
Struck by pole.....	—	—	1	1
Crushed between trains.....	—	—	3	3
Crushed by auto.....	—	1	—	1
Struck by train.....	—	—	3	3
Bumped by patient.....	—	—	1	1
Total.....	4	7	15	26
Number of autopsies.....	2	1	6	9

ELEVATOR ACCIDENTS

Crushed in elevator.....	—	—	1	1
Total.....	—	—	1	1
Number of autopsies.....	—	—	1	1

ASPHYXIATIONS

	Va.	Md.	D.C.	Total
Illuminating gas (suicides not included).....	—	—	4	4
Coal gas.....	—	—	1	1
Carbon monoxide (motor exhaust).....	—	—	2	2
Carbon monoxide (other than illuminating gas).....	—	1	4	5
Strangulation.....	—	—	1	1
Totals.....	—	1	12	13
Number of autopsies.....	—	1	3	4
Overlying.....	—	—	1	1
Smothering.....	1	—	16	17
Aspiration of vomitus.....	—	—	8	8
Foreign body in throat.....	—	—	2	2
Totals.....	1	—	27	28
Number of autopsies.....	1	—	11	12
Fell from boat or pier.....	—	—	7	7
Fell into pool.....	—	—	2	2
Boats capsized.....	—	—	2	2
Bathing—swimming.....	—	—	9	9
Bathtub.....	—	—	1	1
In commode.....	—	—	1	1
Totals.....	—	—	22	22
Number of autopsies.....	—	—	4	4

BURNS

	Va.	Md.	D.C.	Total
Conflagration.....	—	—	2	2
Scalds.....	—	—	5	5
Stove.....	—	1	6	7
Matches.....	—	2	—	2
Lamp.....	—	—	2	2
Bonfire.....	—	1	—	1
Smoking (cigar, cigarets, etc.)..	—	—	6	6
Gas fixture—main.....	—	—	1	1
Explosions:				
Gasoline.....	—	—	1	1
Kerosene.....	—	—	1	1
Stove—boiler.....	1	1	—	2
Totals.....	1	5	24	30
Number of autopsies.....	—	—	2	2

POISONING

	Va.	Md.	D.C.	Total
Arsenic.....	—	—	3	3
Barbital.....	—	—	1	1
Salicylic acid.....	—	—	1	1
Alcohol-methyl.....	—	—	1	1
Carbon tetrachloride.....	—	—	1	1
Total.....	—	—	7	7
Number of autopsies.....	—	—	7	7

SHOOTINGS, ETC.

	Va.	Md.	D.C.	Total
Shooting.....	—	—	1	1
Total.....	—	—	1	1
Number of autopsies.....	—	—	1	1

ABORTIONS

	Va.	Md.	D.C.	Total
Malpractice.....	—	1	4	5
Self-induced.....	—	—	1	1
Spontaneous.....	—	—	1	1
Undetermined.....	—	—	2	2
Total.....	—	1	8	9
Number of autopsies.....	—	1	7	8

GENERAL DISEASES

	Va.	Md.	D.C.	Total
Poliomyelitis.....	—	—	3	3
Measles.....	—	—	1	1
Scarlet fever.....	—	—	1	1
Influenza.....	—	—	4	4
Tuberculosis.....	—	—	41	41
Meningitis.....	—	—	12	12
Syphilis.....	—	—	34	34
Tumor.....	—	—	3	3
Carcinoma.....	—	—	66	66
Tumor of spine.....	—	—	1	1
Diabetes.....	—	—	35	35
Anemia.....	—	—	1	1
Leukemia.....	—	—	1	1
Gangrene.....	—	—	1	1
Addison's disease.....	—	—	1	1
Status lymphaticus.....	—	—	2	2
Alcoholism.....	—	—	9	9
Senility.....	—	—	1	1
Hyperthyroidism.....	—	—	1	1
Acidosis.....	—	—	1	1
Total.....	—	—	219	219
Number of autopsies.....	—	—	40	40

DISEASES OF NERVOUS SYSTEM

	Total for D. C.
Dementia praecox.....	1
Encephalitis.....	1
Abscess of brain.....	1
Meningitis.....	5
Apoplexy.....	91
Epilepsy.....	8
Tumor of brain.....	2
Encephalomalacia.....	1
Total.....	110
Number of autopsies.....	7

DISEASES OF CIRCULATORY SYSTEM

Endocarditis.....	16
Myocardosis.....	222
Coronary disease.....	262
Cardiovascular disease.....	87
Rupture of heart.....	4
Aneurysm.....	1
Arteriosclerosis.....	14
Rheumatic heart disease.....	8
Thrombosis.....	17
Pericarditis.....	1
Hypertensive heart disease.....	105
Embolism.....	2
Cardiac asthma.....	16
Total.....	755
Number of autopsies.....	61

DISEASES OF THE RESPIRATORY SYSTEM

Laryngitis.....	1
Bronchitis.....	4
Pneumonia.....	89
Pleurisy.....	2
Abscess of lung.....	1
Empyema.....	1
Pulmonary embolism.....	3
Pulmonary edema.....	1
Asthma.....	8
Tracheo fistula.....	1
Total.....	111
Number of autopsies.....	21

DISEASES OF THE DIGESTIVE SYSTEM

Abscess of tonsil.....	1
Gastroenteritis.....	8
Gastric ulcer.....	3

DISEASES OF THE DIGESTIVE SYSTEM—Continued

	Total for D. C.
Appendicitis.....	7
Hernia.....	1
Intestinal obstruction.....	16
Diarrhea.....	23
Yellow atrophy of liver.....	2
Hepatitis.....	2
Cholelithiasis.....	2
Peritonitis.....	4
Pancreatitis.....	2
Cirrhosis of the liver.....	14
Gastritis.....	4
Duodenal ulcer.....	9
Diverticulitis.....	1
Septic sore throat.....	1
Gangrene of intestines.....	1
Total.....	101
Number of autopsies.....	11

DISEASES OF THE GENITOURINARY SYSTEM

Nephritis.....	8
Uremia.....	4
Salpingitis.....	1
Pyonephritis.....	2
Tubo-ovarian abscess.....	2
Cardiorenal disease.....	114
Hypertrophy of prostate.....	1
Fistula of bladder.....	1
Total.....	133
Number of autopsies.....	46

THE PUERPERAL STATE

Ectopic gestation.....	2
Postpartum hemorrhage.....	2
Toxemia of pregnancy.....	1
Separation of placenta.....	1
Total.....	6
Number of autopsies.....	1

DISEASES OF SKIN AND THE CELLULAR TISSUES

Cellulitis.....	1
Total.....	1
Number of Autopsies.....	—

DISEASES OF THE BONE

	Total for D. C.
Osteomyelitis.....	2
Total.....	2
Number of autopsies.....	—

MALFORMATIONS

Congenital heart.....	16
Congenital malformation.....	18
Congenital anomaly.....	2
Hydrocephalus.....	3
Total.....	39
Number of autopsies.....	2

EARLY INFANCY

Atelectasis.....	21
Malnutrition.....	1
Hemorrhage neonatorium.....	8
Icterus neonatorium.....	1
Injury at birth.....	44
Prematurity.....	240
Lack of postpartum care.....	12
Marasmus.....	2
Total.....	329
Number of autopsies.....	10

STILLBIRTHS

Stillbirths.....	380
Total.....	380
Number of Autopsies.....	—

ANESTHESIA

Anesthesia.....	2
Postoperative shock.....	1
Total.....	3
Number of autopsies.....	1

LEGAL EXECUTIONS

None.....	
EXPOSURES.....	
None.....	

WAR CASUALTIES

	Total for D. C.
Military.....	1
Total.....	1
Number of autopsies.....	—

REPRINTS RECEIVED

The following reprints have recently been received, for which due acknowledgment is made:

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“Venereal Disease Public Educational Program.” Herman Goodman. Medical Record, February and March 1944.

“Activities of the Naval Hospital at Pearl Harbor Following the Japanese Air Raid of December 7, 1941.” Reynolds Hayden. American Journal of Surgery, May 1943.

“The Psychoneuroses of War.” J. L. Henderson and Merrill Moore. New England Journal of Medicine, March 9, 1944.

“Effect of Long Ultraviolet and Near Visible Radiation on the Eggs of the Nematodes Enterobius Vermicularis and Ascaris Lumbricoides.” Myrna F. Jones and Alexander Hollaender. Journal of Parasitology, February 1944.

“Rapid Rehabilitation in the Shipbuilding Industry.” Kenneth A. Koerber. American Journal of Surgery, February 1944.

“A Report of Living Individuals Who Have Had Proved Cancer.” Eleanor J. Macdonald. Connecticut Health Bulletin, April 1944.

“The State-Wide Cancer Record Registry in Connecticut.” Eleanor J. Macdonald. Medical Woman’s Journal, April 1944.

“Studies on Reducing Substances and Gas Formation in Cultures of Endamoeba Histolytica and a Single Species of Symbiotic Bacteria.” Theodor Von Brand, Charles W. Rees, Leon Jacobs and Lucy V. Reardon. American Journal of Hygiene, May 1943.

“Thiouracil in the Treatment of Thyrotoxicosis.” E. M. Watson and L. D. Wilcox. Canadian Medical Association Journal, 1944, 51, 29.

“Experiments in the Cooking of Garbage for the Destruction of Trichinae in Pork Scraps.” Willard H. Wright and John Bozicevich. Public Health Reports, March 5, 1943.

“Intradermal Reactions Following the Use of Dirofilaria Immitis Antigen in Persons Infected with Onchocerca Volvulus.” Willard H. Wright and John R. Murdock. American Journal of Tropical Medicine, May 1944.

“Present and Post-War Health Problems in Connection

(Continued on page 48)

War Section

LETTERS FROM PHYSICIANS IN THE ARMED SERVICES

From Major George Tolstoi, c/o Postmaster, New York, N.Y.:

Dear Ted: . . . It has been interesting to watch the reaction of those at home as the prognosticators finally admitted failure. Of course, those who are closest are least likely to hazard a guess but I'm not too unoptimistic—unfortunately American casualties continue while the Germans make up their minds—if they still have such an appurtenance.

Your letters are a source of great satisfaction. It's good to hear from and about the various men at home—conversely—perhaps it would be a good idea to join our letters and produce a composite picture of life in the various theaters—many of us can furnish good anecdotes.

From Lt. Colonel Morris Chase, c/o Postmaster, New York, N.Y.:

Dear Ted: Received your news letter of 7th July just a few days ago and enjoyed every word of it. I haven't been at the address you have of me for the past five months. My new address is at the heading of this letter. Will you please see that the MEDICAL ANNALS also is sent on here. Next month will be a year that I've been out of the United States and I am beginning to miss the old stamping grounds a little. Fortunately, I've been rather busy and so tired at the end of the day that going to sleep has been a pleasure. I don't want you to think that I am suffering, however. . . . The cook makes the nicest ice cream (no malteds), we have the best mess in the ETO barring none and a very congenial crowd to work with. I have been to London a few times but living out in the provinces as long as I have, the big city scares me. I hope that all the committees that are assigned to do something for the men who have given up practices to enter the service and some of those who left for the service without ever having had a chance to open up a practice are doing more than just passing resolutions and making reports. I am not speaking for myself because I imagine that I will not have to come to the Society when I get back . . . but am speaking for those who will really be in need of advice and help. They are going to be helped not only to set up again where they left off but also to return to civilian ways of life psychologically. That is going to be quite a problem. Hope they are not working you to death and am waiting impatiently for the next news letter. I get quite a lot of pleasure from them.

I am sorry that for security reasons I can't write you a real letter but that will have to wait till we can sit across the table from each other and over a shot of Scotch pass a very entertaining evening. I suppose you will have many such an evening after this mess is over and it can't end any too soon for me.

From Major Daniel F. Sultenfield, c/o Postmaster, New York, N.Y.:

I am sure that every medical officer who received a copy of your letter of 6 September 1944 enjoyed same. The depth of that enjoyment probably, and properly, bears a direct relation to how long and how far away from Washington the recipient was. (Darn, that's a clumsy sentence but I believe it makes sense!)

In the second paragraph of your good letter you dare venture into the future of the war. I genuinely believe history will confirm your sentiments. Too bad you cannot perform the miracle of converting some 40,000,000 people! Could you do so you could cut a few months off your prognosticated time, which, incidentally, you give by implication only. (Good diplomacy—and no pun intended.)

An interesting idea has just come to me—to wit: "While the people of the District of Columbia are still without vote, the people of the Nation, particularly medical societies throughout the Nation, will eventually come to expect the Medical Society of the District of Columbia to take a leading role in creating and leading the new medical order that is bound to befall our Nation. People, both lay and professional, will come to realize more and more that there is in Washington a great body of medical men and citizens who have the Nation's health welfare at heart. Who compose this body? They are the physicians of Washington who come from most, if not all, states of the Nation. There, in Washington, they work harmoniously, and are in contact both professionally and socially with state legislators and leaders from all states. It is at once obvious, then, that this body of physicians and citizens enjoy occupying the unique and logical position of being the one group who can profoundly influence those who mould the course of our Nation's new health program." (Am I smoking the opium pipe or gazing into the crystal ball? Neither, I hope!)

Rumor has it that Georgetown is going to get a new, and much needed, hospital. Fine! Has the plan been announced officially?

I've just written my old Chief, Wallace Yater, that I promise to read his new edition of "Fundamentals of Internal Medicine" in a foxhole if he'll send me a copy. That sounds silly offhand, but I'm sure I can fulfill my end of the contract. It's this way: The front line is more mythical than real. In our dash South and across France of over 400 miles, I have yet to see a guy who knew exactly where the front line was. There are many, including medical personnel, who have suddenly become aware that they were in hostile territory, but they could define no line. Still all those chaps have found a foxhole to be, not a convenience, but an honest-to-goodness

piece of life insurance—the kind that pays daily dividends in actually keeping a fellow alive.

Good luck with the Annual Scientific Assembly and program. It would be nice to look in on you.

From Lt. J. Leonard Conley, c/o Fleet Postoffice, San Francisco, California:

Dear Ted: Still doing business at the same place and that place is one of continuous heat. It never varies and there are not air-cooled movies out here. Not too long ago met Dr. William Murphy who practiced in Rockville, Maryland. He looked the picture of health although the good color he had was due to both sun tan and atabrine. If they don't get tan one way, the atabrine gives it to them.

My mother wrote about the two new hospitals going up in D.C. The G.W. one will cause some of my friends to move for it will be erected just a block from my home.

We are now permitted to say we were in the invasion of Leyte, Philippine Islands, but we arrived two days after the landing and left the same day so we missed the fireworks . . .

Thanks again for your letters. They are still tops.

From Lt. Comdr. James H. Gillen, c/o Fleet Postoffice, San Francisco, California:

Dear Ted: Got your letter of 6 September this afternoon. Certainly enjoyed it. It caused "M" Street, Connecticut Avenue, "F" Street to flash through my mind.

Saw Staff Hawken in July. The next day he and I drove out to see Warren Burch. About three weeks ago I met up with Staff again. This time we took a short boat ride and visited Joe Belair for awhile. Also saw Herman Hoffman recently.

It is nice that some of the boys are getting back to the District. Whenever Washington men meet the topic of when we get back always comes up.

Have been receiving the overseas edition of the *Star*. It sure is a nice copy and read by many not from the District or its environs.

No news to give from these parts. It is hot as hell and has been for months. A change will be welcome when it comes.

From Comdr. O. Hugh Fulcher, c/o Fleet Postoffice, San Francisco, California:

Dear Mr. Wiprud: I have welcomed and enjoyed so much your chatty . . . visits in the form of letters. The warmth of these communications has made me feel often that I was actually in your office listening to your account of the personal things that have occurred. These letters have been sources of much fun and much information.

It was July 14, 1942 when I was last in Washington. I have been overseas for twenty-one months so I am hoping that ere long I shall be returned for a little tour of continental duty. One becomes a little tired of the coconut groves and the perpetual heat. One grows older rather rapidly too, and frequently he has time to do some good thinking. He learns even more to appreciate educational institutions, his friends, his family; but even more so in comparison does he realize

CALENDAR OF MEETINGS

December 6	Scientific Meeting of Society
December 7	Section on Neurology and Psychiatry
December 13	Scientific Meeting of Society
December 14	Subcommittee on Child Welfare
December 20	Subcommittee on Prepaid Medicine
December 22	Section on Pathology and Laboratory Medicine
December 23	Executive Board
December 28	Special Building Committee
December 29	Board of Censors

the magnificence of our country. I am sure that many of us have been "cured" of the desire to travel abroad.

I have been in large hospitals at the front and in the rear. Our experience represents all that can be crowded into two years of time. It has varied from digging ditches, clearing the jungles, constructing buildings, driving a ten-wheel truck to transportation in a private plane to perform operations. In addition to my duties as neurological surgeon, I have at one time been chief of the department of psychiatry; at another chief of the department of general surgery. It has all been great but right now I am thinking of the thrill that the sight of the dome of the Capitol will afford. I am thinking of the River, the Mall, the Reflecting Pool and the pretty rolling country that is associated with four seasons of the year. It all appears like a dream but I shall expect to be returning before long . . .

P.S. I do not believe that the members of the medical profession should worry too much about attempting to increase the longevity of, for instance, the natives of Guadalcanal. Even though these people die at the age of 25, they will have long since learned all and seen all. Comparatively speaking, they have lived much longer than the people of the U.S.A. Also they don't know their ages, anyway, and many think that they must be ancient.

MEETINGS

Wednesday, February 14

PREVENTIVE MEDICINE (15 min.): "Tests for Drunken Drivers," O. B. HUNTER, M.D., F.A.C.P., Washington

The Washington Urological Society has invited as guest speaker, AUSTIN I. DODSON, M.D., F.A.C.S., Professor of Urology, Medical College of Virginia, Richmond. Dr. Dodson will present a paper on "Management of Nephroptosis."

Wednesday, February 28

PREVENTIVE MEDICINE (15 min.): "Venereal Disease Prophylaxis," NORVELL BELT, M.D., Washington

The remainder of the program will be in charge of the *Section on Gastroenterology*. Speaker and subject will be announced later.

On The Home Front

A regional meeting was sponsored by the **Council on Medical Service and Public Relations of the American Medical Association** at the Mayflower Hotel in Washington on December 6. Representatives of medical societies and other groups by states attending this meeting were as follows:

Delaware: Drs. W. O. LaMotte and M. A. Tarumianz; *District of Columbia:* Theodore Wiprud and Drs. C. B. Conklin, Frank D. Costenbader and Henry C. Macatee; *Maryland:* Dr. W. H. Toulson; *New Jersey:* Drs. Joseph F. Londrigan, Norman M. Scott and L. Samuel Sica; *New York:* Dwight Anderson and Drs. W. P. Anderton, John L. Bauer, H. H. Bauckus, E. R. Cuniffe, Robert R. Hannon, J. Stanley Kenney and Carlton E. Wertz; *Pennsylvania:* Lester H. Perry and Drs. William Bates, F. F. Borzell, Clarence C. Campman, Walter F. Donaldson, George S. Klump, C. L. Palmer and C. C. Rinard; *Virginia:* Drs. H. B. Mulholland, I. C. Rigin and W. Pierce Ruker.

Others in attendance were James J. Boyle, Mac F. Cahal, Thomas A. Hendricks and W. A. Richardson.

Dr. John H. Fitzgibbon, Chairman of the Council, presided. The session was given over largely to the discussion of socioeconomic phases of medicine. Speakers were Dr. Joseph S. Lawrence, Director of the Council; J. W. Holloway, Director of the A.M.A.'s Bureau of Legal Medicine and Legislation; Lt. Colonel Harold C. Leuth, M.C., A.U.S., Liaison Officer, A.M.A.; and Dr. Carl M. Peterson, Secretary of the A.M.A.'s Council on Industrial Health.

During the session, statements were issued to the press by Dr. Fitzgibbon and Dr. Louis H. Bauer, a member of the Board of Trustees of the American Medical Association. In the latter release, a health program agreed upon by the Council was announced. This program appears elsewhere in this issue of the *MEDICAL ANNALS*.

A two-day conference was held by the **Physicians' Forum, Inc.** of New York at the Willard Hotel, Washington on December 8 and 9. Dr. Ernst P. Boas, presided.

At the conclusion of the meeting, Dr. Boas predicted that a national organization of physicians, labor leaders, and social workers will soon be established to rally public support for compulsory national health insurance legislation in the new Congress.

The District of Columbia Rehabilitation Service has announced the appointment of the Professional Advisory Committee. Members of the Committee are:

Medicine: Drs. Bernard W. Leonard, A. Barklie Coulter, Winfred Overholser, Guy Whitman Leadbetter, G. Haven Mankin, Benjamin Rones, Harold W. Krogh (Dentistry) and Howard Payne (Freedmen's Hospital).

Hospital Administration: Dr. J. M. Orem and Mr. Douglas West, Director, Hospital Permit Bureau.

Public Health: Drs. John W. Cronin, George C. Ruhland, and Ella Oppenheimer.

Allied Medical Professional Fields: Miss Wilma West of D. C. Occupational Therapy Association; Miss Laura Field, D. C. Chapter of American Physical Therapy Association; Miss Gertrude H. Bowling, representing the Instructive Visiting Nurse Society and the Graduate Nurses' Association; and Mrs. Barbara Hodges of the American Association of Medical Social Workers.

The Service has been authorized by Congress "to provide any services which are necessary to disabled individuals residing in the District of Columbia fit to engage in a remunerative occupation. Such services include the corrective therapy for static disabling conditions which will enable individuals to become employable or more advantageously employable. The over-all program includes these services: surgical, medical, psychiatric and dental care, hospitalization, physical and occupational therapy, artificial appliances, vocational counseling and guidance, training and placement in suitable employment.

"For any of the medical services and for maintenance, the individual must show evidence of his

inability to pay for such services, except for war disabled civilians and civil employees of the United States injured in the performance of their duties. The latter must show economic need for maintenance only. Any disabled individual 16 years of age or over is eligible for referral to the agency providing he is living in the District of Columbia and such residence is for other than temporary purpose."

A health and hospital survey of the Washington Metropolitan Area was authorized by the newly created **Washington Metropolitan Health Council** on December 18. The Council held its first meeting at the Mayflower Hotel where it perfected its main organization and laid plans for the future.

The following were elected to the Council's Executive Committee: Dr. Winfred Overholser, B. M. McKelway, Associate Editor of the *Star*; Major General U. S. Grant III, Chairman of the National Capital Park and Planning Commission; Mrs. William Carter Bowles, member of the Public Health Lay Council of Montgomery County; Edmund D. Campbell, Attorney, of Arlington County; Vice Admiral Ross T. McIntire; Robert Watt, International Representative of the American Federation of Labor; Theodore Wiprud; and Dr. Garnet C. Wilkinson, Assistant Superintendent of District Schools. Ex officio members of the Committee are: Dr. Herbert P. Ramsey, Chairman; Randolph C. Bishop, Executive Secretary of the National Dental Hygiene Association, Inc., Vice Chairman; and Howard Strong, Executive Secretary of the Health Advisory Council of the U. S. Chamber of Commerce, Vice Chairman.

Chosen as Chairman of the Council's Committee on Survey was Vice Admiral McIntire.

The Section on Neurology and Psychiatry presented the following program on December 7: "The Effects of Low Sodium Chloride Intake in the Treatment of Insomnia and Tension States," by Dr. Michael M. Miller, and "Reflections on Constitution and Environment," by Dr. Benjamin Karpman. Discussion was opened by Dr. Solomon Katzenelbogen.

Dr. Paul F. Dickens addressed the **Section on Gastroenterology** December 4 on "Jaundice." He also discussed briefly the District of Columbia Procurement and Assignment Service.

The Clinico-Pathological Society held a dinner meeting on December 5 at the United Nations Club. Dr. J. P. Leake addressed the group on "Poliomyelitis." Dr. William H. Hough spoke on "Post-arsphenamine Jaundice."

The Louis Mackall Medical Society held a meeting at the Mayflower Hotel on October 18. Dr. Edgar E. Quayle presented a case report on penicillin. At a meeting of the Society on November 16, Dr. Karl Dortzbach spoke on "The Viewpoint of the General Practitioner."

The Very Reverend Lawrence C. Gorman, S. J., President of Georgetown University, broke ground for the University's new hospital at 3900 Reservoir Road, N.W. on December 18. It is expected that the hospital will be completed in one year. Dr. Gorman was assisted in the ground breaking ceremonies by the **Reverend David V. McCauley, S. J., Dean of the Medical School**. In attendance were groups of Cadet Nurses from the Collegiate Nursing School, Sisters of St. Francis, who conduct the hospital now at 35th and N Streets, faculty members and medical students under the Army Specialized Training Program and Navy V-12 training courses at the University.

A gift of \$25,000 was made to **Children's Hospital**, Washington, by Alexander Hecht, President of the Hecht Company, and Mrs. Hecht toward the cost of the new hospital wing now under construction.

The Silver Spring Hospital Association is sponsoring a drive to raise \$700,000 to build a hospital. Mr. Fred L. Lutes is President of the Association.

The District of Columbia Chapter of the American Red Cross is conducting a campaign to recruit Nurses' Aides. The following physicians, at the request of the Medical Society, have participated by speaking to audiences throughout the city: Dr. John M. Orem addressed the Women's City Club on January 3; Dr. James A. Gannon, the League of Republican Women on January 8; Dr. Oscar B. Hunter, the Political Study Club on January 20; and Dr. William M. Ballinger, the Federation of Women's Clubs on January 22.

On December 14, **Dr. William P. Herbst** addressed the professional personnel of the National Cancer Institute, Bethesda, Maryland on "Cancer of the Prostate." On December 20, he spoke on "Tuberculosis of the Genitourinary Tract" at a meeting at Glenn Dale Sanatorium.

The following Washington physicians were elected Fellows of the American College of Surgeons in 1944: **Drs. Leonard S. Berman, Radford Brown, Clarence K. Fraser, Luther W. Gray, Raymond T. Holden, David H. Kushner, George H. McLain and Alfred Wilson.**

Dr. Winfred Overholser, Superintendent of St. Elizabeth's Hospital, addressed a conference on educational problems after the war attended by educators from Washington universities and schools on December 9. His subject was "Psychiatric Bases for Readjustment of Returning Soldiers."

Dr. Caroline Burpeau has been appointed to the School Medical Inspection Bureau of the Health Department, Dr. Joseph A. Murphy, Chief of the Bureau, announced on December 22. Dr. Burpeau took up her duties on January 2, 1945. She is a graduate of the George Washington University School of Medicine, class of 1943.

Commander Gerald H. McAteer of the Navy Medical Corps has been assigned to the Navy's newest heavy cruiser, *Chicago*, it was announced on January 1.

Commander McAteer, well known to Washington physicians, was aboard the carrier *Hornet* when it was lost in battle off the Santa Cruz Islands. He was awarded the Silver Star and the Purple Heart.

Among the physicians in the services who called at the Society's office during the past month were **Lt. Commander A. J. B. Connolly, Lt. Colonel William W. Chase and Major J. Lawn Thompson, Jr.**

The following physicians have subscribed to **Medical Bureau** since November 1:

Alternate Listing Service: **Drs. John N. Andrews, Irving Burka, Caroline F. Burpeau, John P. Clum, Leo I. Donovan, Edward Durkin, William J. Evans, Joseph P. Kenrick, William C. Meloy, Maurice Mensh, Eugene A. Patouillet, Maurice Protas,**

Grace G. Purse, William H. Spicer, and Daniel B. Washington.

Telephone Secretarial Service: **Drs. W. Sinclair Bowen and William B. Marbury.**

Eugene Meyer, Editor and Publisher of the *Washington Post*, was elected President of the **National Committee for Mental Hygiene** by its Board of Directors in New York on December 15. Mr. Meyer is the first layman to be chosen head of the Committee in the 34 years of its existence. As President of the organization, Mr. Meyer will also serve as Chairman of the Board of Directors, succeeding Orlando B. Willcox of New York.

G. Howland Shaw, who recently retired as Assistant Secretary of State, was elected President of the American Foundation for Mental Hygiene at a meeting held on the same date in New York.

ELIJAH WHITE TITUS, M.D., F.A.C.S.

(1885-1944)

Few Washington physicians were as widely known and as well liked as Dr. Elijah White Titus who died after a brief illness on December 11, 1944. Dr. Titus was one of the country's leading obstetricians and gynecologists. Known to his friends as "Ti," he was intensely loyal to those close to him.

Dr. Titus was born in Leesburg, Virginia, February 16, 1885. He attended Leesburg Academy, coming to Washington at an early age. He attended public schools here and graduated from the George Washington University School of Pharmacy in 1905. Later he studied medicine at George Washington receiving his degree in 1910.

He served his internship at Columbia Hospital the following year, later going to Casualty Hospital. In subsequent years he did postgraduate work at Columbia Hospital and served a year's residency at Women's Hospital in New York City.

Dr. Titus was a member of the Medical Board and of the Board of Governors of Columbia Hospital. He was also a member of the medical staff at Garfield Hospital and consultant in gynecology at Children's Hospital.

For more than 25 years he was Clinical Professor

of Obstetrics and Gynecology at George Washington University School of Medicine. He was recently honored by the University's Alumni Association which presented him with a certificate in appreciation for his quarter of a century of service.

He became internationally known through his membership in the Obstetrical and Gynecological Travel Group, an organization which visited various countries for the purpose of studying recent scientific developments. Dr. Titus was active in making arrangements for the visit here in 1939 of fifty British specialists who toured this country.



ELIJAH WHITE TITUS, M.D., F.A.C.S.

Dr. Titus was a member of the Medical Society of the District of Columbia, Washington Gynecological and Obstetrical Society, Hippocrates-Galen Medical Society and the George Washington University Medical Society of which he had been President. He was also a Fellow of the American College of Surgeons and of the American Board of Obstetricians and Gynecologists. His club affiliations included Chevy Chase, Cosmos, Gibson Island and Blue Ridge Rod and Gun Club. He was also a member of the Harmony Masonic Lodge.

Surviving him are his wife, Mrs. Julia Dove Beardsley Titus; two children, a daughter, Mrs.

Aileen Titus Titus, of Kent, Connecticut, and a son, Seaman Second Class E. W. Titus, Jr.; two grandchildren and a sister, Mrs. John T. Hourihane, of Leesburg, Va.

Dr. Titus will be sorely missed by the medical profession of Washington. As those who knew him intimately are aware, he is truly a casualty of this war. He said on a number of occasions recently that he knew he was working too hard but he felt it his duty. This was characteristic of "Ti" for he never shirked a responsibility.

JOHN CONSTAS, M.D.

(1875-1944)

Dr. John Constas, an Active Member of the Medical Society of the District of Columbia, died December 7, 1944, at his home, 1111 Massachusetts Avenue, N.W., following a brief illness. Dr. Constas had practiced in Washington for forty years.

Born in Gargalianous, Greece, on March 14, 1875, he came to the United States at an early age, having worked his way around the world on a tramp steamer. Upon arriving in America, he settled in New England before coming to the District of Columbia. Here he worked his way through Georgetown University, graduating with second highest honors in 1904. He joined the staff of Georgetown University School of Medicine as Assistant in the Department of Anatomy and Surgery in 1909. In 1912 he was made Assistant Professor of Operative Surgery and Assistant to the Professor of Surgery in Genitourinary Diseases. In 1917 he was made Associate Clinical Professor of Surgery, remaining on the staff until 1924.

Dr. Constas was a member of the medical staffs of Gallinger and Garfield Hospitals.

He received the Order of the Golden Cross of Phoenix in 1937 from the Greek minister in behalf of King George II of Greece. The Cross was given in honor of his accomplishments in the field of medicine and his interest in public health in his native Greece.

Surviving him are his wife, Mrs. Maude Constas, and two sisters, Mrs. George Chaconas of 1346 Montague Street, N.W., and Mrs. James Poulos of 113 E Street, N.W.

HENRY FENNO SAWTELLE, M.D.

(1878-1944)

Dr. Henry Fenno Sawtelle, an Associate Member of the Medical Society of the District of Columbia, died of a heart attack at Arroyo Grande, California, on December 2, 1944.

Dr. Sawtelle was born in Norfolk, Virginia, September 24, 1878. He obtained his degree of Doctor of Medicine at the University of Illinois College of Medicine in 1902. He began practicing in Washington in 1906. Appointed Assistant Health Officer of the District of Columbia in 1908, he served in this capacity for four years. He was a member of the Board of Examiners for the District Police and Fire Departments during this period.

During World War I, Dr. Sawtelle commanded the District Field Hospital No. 165 in France and was commissioned a major in the regular army in 1920. Five years later he resigned and resumed his practice in Washington. For the past nine years he has lived in California.

He was a member of the Association of Military Surgeons and of the American Medical Association.

Dr. Sawtelle is survived by his wife, Mrs. Kathleen Sawtelle, and a sister, Mrs. Marion Gloetzel, Glendale, California.

(Rehabilitation of Veterans—continued from page 11)

of the administration of physical therapeutic techniques of all physical agents, and they should always be given under medical supervision and by trained technicians and aides.

7. In the Veterans Administration, the efforts of the internist, surgeon and specialist are supplemented by physical medicine, occupational therapy, physical therapeutic exercises, recreational therapy and library activities, all combined to effectively carry out the physical rehabilitation program for disabled veterans.

(Reconditioning in Hospitals—continued from page 17)

change ideas which have been in vogue for several hundred years. These data are now accumulating and will gradually make an impression in the

curricula of medical schools. As far as public opinion is concerned, a great start has been made by dissemination of factual information concerning the United States Army Medical Department's program. Enthusiasm will grow only as the economic, social and medical advantages of such a program are presented and explained to the public which must pay the bill for such a revolutionary change in medical practice.

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(War Loan Campaign—continued from page 36)

"This was not a one-man job or a one committee job, but an organizational job that required support from bottom to top," he continued. "I take this opportunity to thank each and every one of you for your help, and to assure you that once again the District Medical Division resumes its place with those groups that have distinguished themselves in financing the war effort."

(Reprints Received—continued from page 41)

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SOME MEDICAL ASPECTS OF INFLAMMATORY LESIONS OF THE LOWER GASTROINTESTINAL TRACT*

JOHN TILDEN HOWARD, M.D.

Baltimore

 IN THE limited (and, for you, very wisely limited) time this morning I wish to discuss two medical aspects, the diagnosis and the medical treatment, of three inflammatory conditions of the colon, viz., idiopathic ulcerative colitis, diverticulitis, and lymphogranuloma venereum.

IDIOPATHIC ULCERATIVE COLITIS

The diagnosis of nonspecific ulcerative colitis may be strongly suspected at the examining table or at the bedside, but it is only made with certainty after specific affections of the colon have been excluded by laboratory tests, proctoscopy, and the barium clyisma. However, even in these busy times and with good laboratory service so readily available we should continue to listen to the history of the patient who complains of chronic diarrhea with blood and mucus in his stools, lest we forget that we are clinicians and unconditionally surrender to the laboratory and to its test tubes our privi-

lege of making the diagnosis after all data have been assembled. We should be particularly interested in the mode of onset of the trouble, and we would like to know whether or not it began suddenly or gradually and what the patient can remember of the circumstances which surrounded the initiation of his symptoms. It is interesting to hear of remissions and exacerbations and of the number and character of the stools. Sometimes it is helpful to know whether the diarrhea has been influenced by eating or by the hour of the day. Very rarely non-specific ulcerative colitis may be found in a patient who is passing formed stools covered with blood and mucus. It is wise to inquire concerning fever, for that is a fair index of the acuteness of the process. Perhaps one will ask a few questions concerning the patient's background of allergy and concerning his experiences with different foods. But too much importance should not be given to the story of allergy, since recrudescences of the colitis may have been concurrent with the eating of certain foods rather than because these foods were taken. Recently more and more attention has

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been paid to the psychologic factors in non-specific ulcerative colitis, and it is always well to trace the relationship of the beginning or of the exacerbations of the trouble to strain, to worry, or to maladjustment, if that can honestly be done. Then, too, one may probe for the circumstances attending periods of improvement.

At the physical examination attention is paid to the patient's nutrition and hydration, for in amebic dysentery the general condition of the patient is often surprisingly good in contrast to the usual rather poor condition of the patient with idiopathic ulcerative colitis. The temperature is taken and the joints are inspected for the presence of arthritis, a rather common complication of ulcerative colitis and bacillary dysentery. The lips and tongue may give evidences of a deficiency state, which may be primary, but which is more likely to be secondary to the colitis. Abdominal tenderness and spasticity or palpable thickening of the colon may be noted. At the initial session of the colitic patient I usually make a proctoscopic examination, since even without previous preparation of the bowel, much information can often be obtained. Certainly proctoscopy is simple enough and, like the digital rectal examination, it may be considered to be a part of the physical examination; in my opinion, it is hardly deserving of the place in the operating room to which some surgeons elevate it and of the ritual of the sterile technic with which they surround it. Probably a little "medical asepsis," such as the washing of hands and the boiling of instruments, is adequate for the procedure. To be sure, one may not see all that he wants to see at the initial proctoscopic examination which I have suggested. Still, it is informative to find hard, blood-covered scybala in a bowel with a diseased mucosa, and usually satisfactory specimens may be obtained for culture and for microscopic examination at the patient's first diagnostic session. Recently I have been using as my 'scope an open tube with proximal lighting; it has a diameter of 15 mm. and a length of 20

cm. Through the open tube fluid stool can be aspirated or drained easily and one can really see the mucosa very clearly. Then, too, the patient appreciates the relatively slight dilatation of the rectal sphincter which is required in the use of this proctoscope. It increases the rapport between doctor and patient to treat him with gentleness, and it is pleasant to have a patient say, after one has had an adequate view of the mucosa of the rectum and lower sigmoid, "That was the easiest examination I ever had."

With the proctoscope in cases of nonspecific ulcerative colitis mucosal changes of granularity, friability, hyperemia, intramucosal hemorrhages, pin-point ulcerations, or large necrotic areas may be seen, depending on the stage of the disease. Frankly, I cannot diagnose with certainty nonspecific ulcerative colitis from the proctoscopic picture alone, though I can suspect it very, very definitely. I am not able to distinguish the lesions of bacillary dysentery from those of idiopathic ulcerative colitis. But sometimes I can make a presumptive diagnosis of amebic dysentery from the proctoscopic appearance of the bowel, since in amebic colitis the ulcerations are deep and punched out and between them the mucosa seems to be normal. Lymphogranuloma venereum cannot be distinguished from idiopathic colitis with the proctoscope, although local scarring and stricture about the anus are suggestive of the former condition and the normality of the mucosa of the upper rectum is sometimes seen in a striking way in lymphogranulomatous proctitis without stricture.

Microscopic examinations of the stools of idiopathic ulcerative colitis and of bacillary dysentery reveal large amounts of pus in both conditions. The stools of amebic colitis are relatively free of pus, and they are likely to contain Charcot-Leyden crystals and at one time or another motile *E. histolytica* will be found in them. The macrophages in the feces of cases of bacillary dysentery must not be confused

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with true amebae, and the doctor will do well to make the microscopic examination of the material obtained through the proctoscope unless his technician is absolutely reliable.

Cultures of the wipings of the wall of the sigmoid and cultures of the stools may show *B. dysenteriae* and so prove the etiology of the colitis. But in the chronic colites such bacteria are notoriously difficult to find. Serologic agglutinations for the dysenteries aren't too reliable unless the organisms are clumped by high dilutions of the patient's serum (at least by 1:80 with Shiga's bacilli, 1:160 with Flexner's and 1:100 with Sonne's).

Probably it is unwise to exclude the diagnosis of a specific colitis at a single examination and usually three or four recently passed stools should be studied before the search for amebae and dysentery bacilli is concluded. It may be necessary to make subsequent proctoscopic examinations after the bowel has been washed with a saline enema, although, as I have indicated, that is usually unnecessary.

In a patient with nonspecific ulcerative colitis examination of the blood may or may not show anemia. An important hematologic finding, as Paulson has brought out, is the elevation of the sedimentation rate in really active ulcerative colitis. A normal sedimentation rate does not exclude the disease, but with such a finding the disease is likely to be extremely mild.

With the opaque clyster such specific causes for bloody diarrhea as carcinoma and diverticulitis may be discovered. In the absence of these conditions, the diagnosis of nonspecific ulcerative colitis cannot be made by roentgen studies of the colon alone. However, such investigations often give some idea of the extent and severity of the process when it is present, and in the relatively rare involvement of an upper segment of the bowel without involvement of the rectosigmoid the roentgen examination is most valuable. In the remissions of the disease one may often learn the extent of the fibrosis of the bowel, and the presence of polypi may be

demonstrated by roentgen studies. Nonspecific ulcerative colitis is often seen at proctoscopic examination when the barium enema shows no abnormality in the colon. Spasm alone is not pathognomonic of the process and it takes the mild case a long time to produce the roentgenologic picture of a "lead-pipe colon"; the fulminating case with its great edema and infiltration of the bowel wall will show skiagraphic changes earlier.

Paulson has demonstrated a probable etiologic relation between the virus of lymphogranuloma venereum and some cases of ulcerative colitis which were formerly termed nonspecific. These patients give positive skin reactions when tested with a Frei antigen; and colonic exudates from these patients give positive reactions when they are applied as an intradermal skin test to individuals who react positively to an antigen obtained from pus of the bubo. The antigen obtained from the colons of such patients gives negative skin reactions in persons who are Frei-test negative. At the present time I think that the lymphogranulomatous variety of ulcerative colitis is of greater academic than of practical interest, and I do not routinely run Frei tests on all patients with colitis, since we are so busy and the treatment of nonspecific ulcerative colitis and of colitis caused by lymphogranuloma venereum is identical in my hands. Since lymphogranuloma improves on sulfonamide therapy, one might think that the patient with ulcerative colitis and a positive Frei test would be likely to obtain a better therapeutic result than would the truly nonspecific case.

I have never been able to recognize the factor of allergy to food in patients with nonspecific ulcerative colitis. To me such allergies have seemed to be theoretically possible, because incompletely digested protein might be easily absorbed from an ulcerated bowel. My failure to recognize an allergic factor in cases of ulcerative colitis does not mean that such an etiology for the disease is nonexistent. Others have reported a causal relationship of certain foods

in patients with the disease, and I respect their observations. They are agreed that skin testing is a most unreliable way to detect allergy to food and that the elimination diet is their most satisfactory diagnostic aid in finding the offending protein. Obviously it would be wrong to put a patient with fulminating ulcerative colitis through a long period of elimination diets; these can be reserved for the more chronic cases of ulcerative colitis if they are used at all.

The treatment of nonspecific ulcerative colitis is, I can assure you, no more satisfactory in Baltimore than it is in Washington. A very well-known clinician of my City one said to me, "When a patient with nonspecific ulcerative colitis comes into my office, I want to jump out the window." Probably his reaction to a case of ulcerative colitis was a bit extreme, but it reflected the rather unsatisfactory status of our medical therapy of the disease. My friend was defeated before he began to treat his patient, and in an unconscious way he probably communicated his pessimism to the victim of colitis.

As the concept of psychosomatic medicine has grown, more and more attention has been paid to the psychologic reactions of patients with idiopathic ulcerative colitis. Perhaps that has been done because we were rather desperate in our search for new therapy; perhaps it came from renewed observations of the association of arthritic attacks with psychic strain; perhaps we recognized the occurrence of hemorrhage and the recurrence of symptoms when persons with peptic ulcerations were thrown into emotional states; perhaps we saw the genuine good which cardiac patients obtained from a buoyant outlook. At any event, we have in hope an old weapon against disease which hasn't been sufficiently used in nonspecific ulcerative colitis, and we have a public which is increasingly cognizant of and willing to correct social and environmental strains that aggravate organic disease. I don't mean to imply that ulcerative colitis is initiated by psychologic factors. But I do believe that every disease has its psychologic

side and that in about one third of the patients who have ulcerative colitis there are personality difficulties, environmental maladjustments, social and economic worries and tensions to which exacerbations of the colitis may be related. The patient with ulcerative colitis is depressed, and he probably comes to his doctor seeking hope as well as a cure. Much can be done with optimism, and I try to keep before myself and my colitis patients the increasing number of cases of nonspecific ulcerative colitis who have such long remissions of symptoms that they seem to be cured by medical measures, or the number who have been practically cured by ileostomy and, perhaps, by subsequent colectomy. One should not make promises and one should not tell falsehoods to patients with colitis. But hope and cheerfulness have always been the doctor's aids, and the shock of truth can be softened by diplomatic telling. It is difficult for the physician to alter many a social or economic problem that is distressing his patient. However, a change of scene, a new job for which the patient is fitted, or a sympathetic listener who will bolster the patient's ego may do great good for the milder case of ulcerative colitis. In the fulminating case such an approach would be as ridiculous as the immediate treatment of a gastric hemorrhage with a sympathetic chat.

It is my own opinion, and one which is not held by many other critical workers, that the sulfonamide drugs have been a valuable adjunct in the treatment of ulcerative colitis. Although they are not always of benefit, improvement in the clinical condition of a patient with such colitis follows the use of these drugs often enough to make me believe that they are genuinely useful. As Rodaniche, Kirsner and Palmer have shown, the absorbable sulfonamides (sulfathiazole and sulfadiazine) and the poorly absorbable sulfonamides (sulfaguanidine and sulfasuxidine) decrease the bacterial count of the feces of patients with chronic nonspecific ulcerative colitis and transform the flora from that in which there is a predominance of coliform

bacilli to one with a predominance of gram-positive bacteria, usually enterococci. Following the suggestion of Mills and Mackie, it is now my habit to give a total daily dose of 4 grams of sulfadiazine to the acutely ill patients, although at times they receive 12 grams or more of sulfasuxidine orally in addition to the sulfadiazine. To the milder cases from 6 to 12 grams of sulfasuxidine are given daily in divided doses. Retention enemata of from 3 to 10 grams of sulfasuxidine have often been useful, and these may be more easily retained if they are preceded by the introduction of a rectal suppository of opium and belladonna.

For the patient with nonspecific ulcerative colitis who is seen relatively early, who is afebrile, whose rectal mucosa is simply friable or shows small ulcerations and intramucosal hemorrhages without large areas from which the epithelium is denuded, and whose stools do not exceed 6 or 8 a day, a smooth diet with purées, additional vitamins, relative rest, sulfaguanidine or sulfasuxidine, antispasmodics, and a constipating powder of equal parts of calcium carbonate, calcium phosphate, and bismuth subcarbonate (a teaspoonful 3 or 4 times a day) may control the situation.

In the febrile patients who have from 10 to 20 stools daily, who are in poor general condition, who have anemia, and who show a rectal mucosa which resembles raw meat, more vigorous therapy is necessary. Of course, absolute rest is essential, and our attention is directed toward the treatment of the patient as well as to the treatment of the colitis. It is most important to keep these patients hydrated and to keep their electrolytes from being depleted by the many stools. Fluids are administered by vein and subcutaneously, and the content of these fluids is regulated by the laboratory reports of the blood chlorides, the serum calcium, the carbon dioxide combining power of the plasma and the total protein in the blood serum. Repeated small transfusions of blood (250-300 c.c.

daily) help the anemia, and they help to replace the plasma protein which is lost in the stools.

The sulfonamides are administered as I have already indicated, and sulfadiazine in doses of 1 gram every 6 hours is usually tried first on the probably erroneous hypothesis that, if the lesion of ulcerative colitis is a submucosal thrombosis, the more absorbable sulfonamide will reach the lesion better than the poorly absorbed one. Both the absorbable and non-absorbable sulfonamides may be given at the same time. With belladonna and Trasentin we try to influence the spasm of the bowel and to lessen the movements with laudanum, with powdered opium, or with a bismuth-containing powder. Although we wish the exudate from the inflamed colon to drain well, we don't want the sulfonamide to be eliminated too rapidly. It is our impression that the sulfonamides do good and that many an ileostomy has been avoided by their use. However, there are many disappointments in store for those who hope for uniformly dramatic results, and we never make predictions about the efficacy of our treatment. The sulfonamides seem to be of most help in the less toxic patients, and, if benefit is to be obtained from them, it is generally apparent in 1 or 2 weeks.

In the severe cases the vitamins should be given parenterally in such daily doses as 200 mg. of ascorbic acid, an ampule of Solu-B, and the universally employed liver extract. I have not given vitamin A parenterally and I have depended on the ingestion of Percomorph Oil to supply vitamins A and D. Theoretically, the use of the sulfonamides might interfere with the bacterial production of vitamin K in the intestine. But tests have shown that, while the level of vitamin K falls when sulfasuxidine is used, the drop is not a significant one.

One adjuvant which is used in the moderately severe cases but less regularly in the fulminating ones is iron; this is taken as ferrous sulfate in doses of 0.4 Gm. 3 times a day. Because I have seen entirely empiric treatment do good,

I occasionally try increasing doses of horse serum for the effect of protein shock and, in those rare cases in which it seems helpful, we believe that the improvement has been the result of subsequent serum sickness. When vaccines do good (and that is rarely), they probably work through the mechanism of shock. I have no hesitation in giving retention enemata of warm cod-liver oil, although I have noted genuine improvement from such therapy in only 1 patient. I mention large colonic irrigations only to say that they have been abandoned. Retention enemata of tannic acid are probably useful at times.

In my experience elimination diets have been of no use to any patient with nonspecific ulcerative colitis. In 1 case of which I know, the patient had a strongly positive skin reaction to milk, but he had taken milk without aggravation of his symptoms. When milk was withdrawn he did not improve.

When does the internist call for surgical help in the treatment of nonspecific ulcerative colitis? You will smile and consider my answer to be unsatisfactory when I say that every case should be individualized and that few rules can be laid down. I do believe that surgery is in order when the entire colon is grossly thickened and when the chronic process has interfered so much with the patient's activities that he is unable to carry on his work because of poor nutrition or uncontrollable diarrhea. Sometimes one may say to the patient with very chronic symptoms, "If you aren't strikingly improved 3 months from today, we will consider you to be a candidate for an ileostomy." This plan of setting a day for surgery sometimes keeps the patient from dragging on endlessly, half sick and half well, when he might be practically well; and it helps him to make up his mind to have the operation. When the interval of waiting is over, the patient has the privilege of rejecting an operation if he is not ready for it. Certainly the victim of colitis and multiple anal fistulae is a candidate for ileostomy rather than for endless treatment of the fistulous tracts.

Certainly strictures of the bowel and polyposis of the colon are indications for surgical intervention. Whether or not the fulminating case should be asked to submit to ileostomy is indeed a problem. One may feel that prompt action will prevent extensive damage to the bowel, but too frequently the process continues in the colon after the ileostomy. However, I believe in the life-saving effect of ileostomy and that it should not be deferred too long. After a month of medical management I am likely to advise the severer cases to have an ileostomy. As I see things, it is better to have the unesthetic surgical setup than a fatal termination of the disease. But I never try to "sell" such an operation to the patient or to his family; I advise it when I think it is indicated but I don't demand it. Too often my colleagues have asked me, "Do you remember Mr. X who left you after you advised an ileostomy? He came to me and had a prompt remission when we gave him retention enemata of Kaomagma." On the whole, there are probably fewer ileostomies done now than were done 10 years ago. At one time, shortly after the introduction of the sulfonamides, I felt that ileostomy should always be deferred as long as possible, and then a little longer. I was wrong in that belief and I no longer hold it. But, when the patient is moribund, it is better to give him his chance to recover with the ministrations of Mother Nature rather than to push him over the edge with the operation, which, by the by, is in no way a minor one. I never forget that I have seen a patient who didn't want an ileostomy get well after surgeons had said to his physician, "Doctor, do you wish Mr. X to die because of your eternal stalling?" That patient is now in the Army and he has had an apparent cure.

There is a large group of patients who recover after ileostomy has been done; they have relatively little colonic difficulty; they are adequately nourished; they do their work; and they remain well. Another smaller group is not improved generally or locally because the process in the colon remains relatively active. A third group

improves systemically for a time and its individuals gain 20 or 30 pounds, but then they take a downhill course. In these last 2 groups the internist is likely to advise colectomy, since it is so apparent that toxins from the infected colon cause the general and local symptoms.

DIVERTICULITIS

I once asked a famous internist how one could best diagnose carcinoma of the pancreas, and I shall never forget his answer to me. He said, "The secret of that diagnosis is to bear the condition in mind." And it seems to me that one might say the same thing about the diagnosis of diverticulitis of the colon; let us bear it in mind. There is some danger that the busy internist will fail to consider the possibility of diverticulitis in patients over 40 years of age who have the classical symptoms of an irritable colon, especially if the patients are a bit emotional and have some psychologic state, such as "war nerves," on which one may lay the blame for the unstable bowel. All the symptoms, including the pain, of the irritable colon (mucous colitis) may be produced by a mild diverticulitis, and all such cases should be studied with the barium clyster and have their leukocytes counted. Rarely do diverticula of the colon fail to show on the skiagram, though very tiny ones may be overlooked at fluoroscopic examination.

Of course the roentgen demonstration of diverticula of the left side of the colon does not absolutely incriminate them as the cause of left-sided abdominal pain and symptoms related to the lower bowel. While they are a likely cause, pelvic inflammatory disease, carcinoma of the colon, and pathology in the urinary tract should be ruled out. There are grades of inflammation in diverticula, and occasionally it may be difficult to decide whether they are the cause of symptoms or simply a concomitant finding when another disease is active. Probably silent diverticulosis of the colon is quite common.

Very acute inflammation in a diverticulum

may simulate appendicitis on the left side with vomiting, fever, and striking leukocytosis. I have never seen such a case go on to rupture or to abscess formation, and that is probably the reason for my continuing to be conservative in the treatment of acute diverticulitis. Undoubtedly peritonitis, abscesses, and fistulae to the exterior or to other viscera do occur and require surgical treatment; I have been fortunate in not having seen such a case.

Repeated or long-continued inflammation in diverticula may produce peridiverticulitis and pericolicitis with thickening and scarring of the colonic wall so that partial obstruction with its attendant symptoms is produced. I have seen 3 such cases in 20 years of practice, but in none of them was I able to exclude carcinoma until the pathologist had examined the resected intestine microscopically.

The treatment of the ambulatory case of diverticulitis is simple and satisfactory. Usually a smooth diet and the management of the bowel without the use of irritant laxatives are all that are necessary. At first the smooth diet contains puréed vegetables and fruits; but in a few weeks purées may be eliminated and the roughage of the diet is simply softened by cooking. It has been my custom to allow patients who are on a smooth diet and who have good dentures to eat lettuce and ripe bananas and ripe tomatoes without special preparation. The management of the bowel movements without the use of irritant laxatives is difficult at times, but usually mineral oil and the soft bulk of thrashed psyllium seed (e. g., Mucilose, Metamucil and Siblin) are sufficient. If necessary, these are reënforced with nightly retention enemata of warm cottonseed oil, and enemata of water are rarely needed. Since spasm is undoubtedly a factor in the formation of diverticula and in preventing the emptying of the pockets after they have been formed, belladonna is an adjuvant in the treatment of diverticulitis. Local heat is also a useful antispasmodic.

In acute diverticulitis with fever and leuko-

cytosis and severe pain, I have been fortunate in the success of conservative measures, as I have indicated. Rest in bed, atropine, heat, a liquid diet, lubrication of the bowel from above and below, the sulfonamides, and close observation for clearly surgical complications have been satisfactory therapeutic measures in my hands. Perhaps I will see my first diverticulitis with abscess formation in this coming week; then I will welcome the surgeon's help.

In patients with diverticula and sufficient peridiverticulitis to produce obstruction to the bowel one will invariably see a filling defect on the skiagram of the colon. Frequently gross blood is passed in the stools of these patients, and I have been unwilling to give medical treatment when a carcinoma might be present in addition to diverticula. It is safer to have the surgeons go in promptly and resect the obstruction, as they have been able to do in a single stage operation in each of my 3 cases, than to drift on "by guess and by God" without real knowledge of the nature of the obstruction. Then, too, such patients are more comfortable when their obstructions are removed than when they are managed by diet and lubrication. But my last word about diverticulitis is spoken in behalf of conservative treatment: I do not believe that colonic resections are indicated in patients with diverticulitis unless obstruction is present or unless a concomitant carcinoma is suspected.

LYMPHOGRANULOMA VENEREUM

The diagnosis of anorectal lymphogranuloma venereum depends on the clinical finding of a proctitis, which is usually confined to the lower rectum, or of an anorectal stricture, with or without proctitis, and a positive Frei reaction in the skin. A positive complement fixation test for lymphogranuloma is confirmatory. While it is true that the accuracy of the diagnosis may be carried a step further by the preparation of an antigen from the rectal exudate and its use in skin tests on persons who are known to

react positively to lygranum, such a test is not usually done. Of diagnostic importance, also, is the clinical observation that practically all rectal strictures with proctitis in colored females are lymphogranulomatous. Frequently one's clinical intuition will make him suspect the diagnosis-confirming homosexuality in males who have proctitis or rectal stricture. In my experience, gonorrheal proctitis is so rare that its consideration in the differential diagnosis is more academic than practical. I have recognized one case of gonorrheal proctitis which was proved by cultures. In the diagnosis of anorectal stricture one should never fail to inquire concerning previous hemorrhoidal surgery, and he must remember that carcinoma of the rectum, although rare in colored women, can occur at any age in anybody. Although a biopsy is usually unnecessary to differentiate the stricture of lymphogranuloma from that of a rectal carcinoma, in cases of doubt it should be taken. I once treated a woman with carcinoma of the vulva which had extended to involve the vagina, rectum and lower sigmoid as a case of lymphogranuloma and I hope never to make that error again. A biopsy would have spared me great humiliation, although it wouldn't have helped the patient, since her lesions were most extensive. Polyposis of the rectum should be kept in mind in the differential diagnosis.

The medical treatment of lymphogranulomatous proctitis is quite satisfactory, since it responds well to the sulfonamides given orally or as retention enemata. Sulfathiazole in doses of 1 gram 3 times a day or retention enemata of 3 grams of sulfasuxidine in 100 c.c. of warm water will produce remarkable improvement in 10 days, and although I can't say that permanent cures are obtained, there are extremely long remissions. Sulfanilamide has been given with a local anesthetic as a suppository in lymphogranulomatous lesions of the rectum, but I have had no experience with that method of application. Of course, chemotherapy doesn't re-

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THE FUTURE OF OUR CORONARIES*

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NO DISEASE occupies a more sinister position in the minds of the public and of the medical profession than coronary artery disease, the incidence of which has increased in the past few years, with an ever increasing tendency to appear among younger persons. This increase is thought by some to be due to the lengthening life span of man, which has meant more candidates in the older age groups for arteriosclerotic heart disease, and to the more accurate methods of diagnosis, particularly in regard to coronary occlusion. By others, the increased incidence is explained on the basis of a disease associated with occupations necessitating high-pressure intellectual activity and probably low pressure or spasmodically regulated physical activity.

The factor or factors of heredity are thought to create an increased susceptibility to the development of arterial disease in some individuals. These individuals are susceptible earlier in life and may be considered candidates for local or widespread arterial disease, culminating in coronary artery disease, predominant involvement of other arteries, hypertension, or various combinations of these conditions. The stresses and strains and increasing tempo of modern living have been given much importance, and undoubtedly play an important role, particularly in cardiovascular candidates.

The full importance of coronary heart disease has not been sufficiently emphasized in the past, particularly in view of the fact that the alarming increase in incidence among younger persons constitutes a serious threat to future generations

unless the cause or causes of the disease can be determined and measures instituted to prevent its progression.

ETIOLOGY

Approximately 10 per cent of cases of coronary insufficiency are caused by such conditions as syphilis of the aorta with stenosis or occlusion of one or both coronary orifices, aortic stenosis or insufficiency, paroxysmal tachycardia, and anemia, in which the heart suffers from anoxemia along with the rest of the body. The remaining 90 per cent are on the basis of coronary arteriosclerosis.

It is apparent, then, that the problem of coronary artery disease is primarily that of arteriosclerosis of the coronary arteries, the causes of which are the causes of arteriosclerosis in general. It has been presumed by some that atherosclerosis represents a degenerative process, one of the inevitable manifestations of the senescence of man, while others have evidenced considerable interest and have undertaken numerous investigations dealing with the causes of arteriosclerosis.

High protein diets were, at one time, believed to contribute to the production of arterial disease, and infections capable of producing arteritis have received some attention as etiologic factors. The more universal and sometimes excessive use of tobacco has been linked with the increasing incidence of arterial disease.

Leary,¹ in 1934, suggested that atherosclerotic changes no longer should be considered as results of an aging process, but rather, that they represent a disturbance in the lipid metabolism of the body, and that atherosclerosis belongs

* Read at the Sixteenth Annual Scientific Assembly of the Society, October 5, 1944.

to the class of metabolic diseases, such as diabetes mellitus and gout. The plasma lipoid studies of Barker² on obliterative arteriosclerotic disease of the extremities, and Willius³ studies on coronary artery disease have shown the existence of hyperlipemia in many cases. Others⁴ have called attention to the frequent coexistence of xanthomatosis with hyperlipemia and coronary artery disease.

There is no clear-cut evidence that any of the therapeutic agents in use so far is effective in the metabolism of cholesterol. Choline will inhibit excessive deposits of neutral fat in the liver, and lipocaic supposedly influences cholesterol metabolism. Prevention, however, by substituting vegetable oils (whose sterols are not absorbed through the animal intestine) for animal fats may give more promise. A recent experimental study has shown that iodine, which has been used empirically for years in the treatment of arteriosclerosis, is deposited in the walls of blood vessels, and that the sclerotic aorta shows a special affinity for the drug.

Although Leary's hypothesis and others have not been definitely proved, they have given the profession food for thought and have opened the way for further investigations in this field.

RECOGNITION

At the present time, then, since the etiology of atherosclerosis and arteriosclerosis, and therefore coronary artery disease, remains unknown, and in the absence of our ability to control the progress of coronary arteriosclerosis, the future of coronary disease depends on two important factors: early recognition of the condition and judicious management.

Coronary artery disease manifests itself in a variety of ways. The commonest of these is the syndrome of angina pectoris. Of equal significance is the syndrome of acute coronary occlusion which may occur without any antecedent evidence that the heart was diseased. The clinical picture of progressive myocardial failure, in the absence of angina pectoris, or of hyper-

tension, may have its basis in coronary artery sclerosis. Also, there is the group of cases in which occult coronary artery sclerosis is discovered only at necropsy, the subjects during life never having exhibited symptoms from which the condition could have been suspected.

The diagnosis of angina pectoris continues to offer difficulty to the medical profession, and the mistakes made most frequently are of two kinds: first, failure to recognize the syndrome; and second, interpretation of thoracic pain as angina pectoris when it is not. There are three characteristics of the anginal syndrome which constitute a diagnostic triad of the condition:

1. *Location of pain.* The distress is almost always situated behind the sternum. Anginal pain may be felt elsewhere in the thorax, jaws, neck or epigastrium, but if such pain is to be considered as angina pectoris, then the relationship of the symptoms must conform in all other respects to that characteristic of the disease. The use of the term "precordial pain" is objectionable inasmuch as pain so described is frequently in the apical region or in the left anterior axillary line, and such pain usually proves not to have its basis in coronary insufficiency. If effort pain is situated retrosternally, the presumption is that coronary disease is the cause, but if the pain is in the lateral thoracic wall, the burden is on the examiner to prove that it is angina pectoris.

2. *Nature of pain.* True anginal pain is precipitated by anything that increases cardiac work: physical exertion, such as walking, excitement, ingestion of food, or a combination of these factors. Angina pectoris is produced much more readily if the patient attempts to exercise soon after eating, against the wind, or in cold weather. This relation of cardiac overload to the onset of the attack is pathognomonic only if the seizure subsides within a few minutes after the provoking factor ceases. As a general rule, any pain in the upper abdomen, chest, neck, shoulders or arms which has a definite relationship to physical exertion should

be considered as angina pectoris until proved otherwise.

3. *Duration of pain.* The attack of angina pectoris is brief. The typical seizure is over in a few minutes, seldom lasting longer than 15 to 20 minutes. Attacks of substernal pain continuing an hour or more should always lead to the suspicion that coronary artery occlusion has occurred.

The diagnosis of angina pectoris must be based on symptoms and not on physical signs. In a relatively large percentage of cases it is necessary to make the diagnosis in spite of negative results of cardiac examination, in the absence of any significant electrocardiographic abnormality, and without any help from roentgenographic examination of the heart.

In some cases the electrocardiogram shows changes which are presumptive evidence of coronary artery disease, such as delays in conduction, either in the bundle of His, or in the bundle branches; prolonged Q waves in lead III; or inversion of T waves. However, except for the classical patterns which may follow acute myocardial infarction on the basis of coronary artery occlusion, there are no electrocardiographic changes which can be said to be pathognomonic evidence of coronary artery disease. Nor will absence of electrocardiographic changes exclude its presence. The recognition, however, of early significant changes, when present, may lead to the instituting of vitally important preventive measures. Electrocardiograms taken during an attack of angina pectoris may show variations in the S-T segment, and decreased amplitude or inversion of T waves, which indicate an inadequate blood supply to the myocardium.

Within the past few years, two diagnostic tests have been introduced, the employment of which may be helpful in ascertaining the presence of latent coronary insufficiency. The "two step" test devised by Master and his associates⁵ depends on the response of the pulse, blood pressure, and certain changes in the electro-

cardiogram after a measured amount of physical effort, produced by walking up 2 steps a designated number of times as determined by the age, height and weight of the candidate, in $1\frac{1}{2}$ minutes. Normally, the blood pressure and pulse rate should return to within 10 points of the resting figures 2 minutes after cessation of the exercise. An electrocardiogram, including the chest lead, is taken before the exercise is begun and is repeated immediately after its completion as well as 2, 4, 6, 8 and 10 minutes later. Using the P-R level as a control, depression of the S-T segment beyond $\frac{1}{2}$ millimeter in any lead indicates a positive test of coronary insufficiency. There is some controversy among cardiologists as to whether the hazards attending the production of an attack of angina pectoris by exercise may be too great to warrant employing such a diagnostic procedure routinely in daily practice.

Levy and his associates⁶ have described the "anoxemia test" in which a patient under basal conditions breathes 10 per cent oxygen for a period of 20 minutes. The electrocardiographic criteria considered to be indicative of inadequate coronary circulation are as follows: (a) the arithmetical sum of the S-T segment deviations in all 4 leads totals 3 millimeters or more; (b) partial or complete reversal of the direction of T_1 , accompanied by an S-T segment deviation of 1 millimeter or more in this lead; and (c) complete reversal of the direction of T_{4f} regardless of the S-T deviation in this lead. Further, the appearance of typical anginal pain within the first 10 minutes of the test may be considered as presumptive evidence of coronary insufficiency. Since the results of this test may be negative in cases in which the clinical evidence of angina pectoris is unmistakable, a negative test does not necessarily exclude coronary artery disease. The method as described by Levy demands that the concentration of oxygen inhaled is not below 10 per cent, that the procedure be interrupted with the onset of unfavorable symptoms, and that 100 per cent oxygen

be available for administration at once should the need arise. In addition, Levy has warned against performing the test in the presence of congestive heart failure within 4 months after a known cardiac infarction, or in the same patient twice within 24 hours.

The typical symptoms and signs of acute myocardial infarction are so well known that it is not necessary to devote time in this discussion to their elaboration. One point, however, should be emphasized, namely, that unannounced attacks of suffocation, or attacks of substernal or epigastric pain not exceeding 30 to 60 minutes, may be indicative of acute coronary artery occlusion, and under these circumstances such an accident cannot be excluded without careful electrocardiographic study.

Lately, much has been written about painless coronary artery occlusion. It is well known that 2 or even 3 main trunks of the coronary arteries may be found occluded at autopsy without the syndrome of coronary artery occlusion having occurred during the subject's life, although most of such patients will have suffered from angina pectoris. Moreover, myocardial infarction or fibrosis may be absent in such cases. Likewise, it is well established that chronic infarction resulting from gradual closure or narrowing of a coronary artery is frequently observed in cases in which the clinical history does not include an episode of pain characteristic of acute coronary artery occlusion. It is not, however, so clearly established that acute myocardial infarction occurs without a fairly characteristic attack of pain, except for the occasional patient who suffers from the equivalent of pain in the form of profound shock or dyspnea.

In the diagnosis of acute coronary artery thrombosis with myocardial infarction, the electrocardiogram often is indispensable. The internist should be conversant with the Q_1T_1 and Q_3T_3 patterns, characteristic of acute myocardial infarction, late as well as early. He should likewise be cognizant of the changes in

the precordial leads that indicate this condition. The investigation of a suspected attack of coronary artery thrombosis may require serial electrocardiographic tracings including the precordial as well as the conventional leads.

Time does not permit a discussion of the numerous conditions, the pain of which may be mistaken for that of angina pectoris or of acute myocardial infarction. A partial list, however, of the problems of differential diagnosis includes myalgias and arthralgias in the region of the left chest or left shoulder, spondylitis, cervical rib, cord lesions, herpes zoster, aortic aneurysm, acute pericarditis, pulmonary embolism, diaphragmatic hernia; the precordial pain reference of biliary tract disease, pancreatitis, peptic ulcer, etc.; and other systemic conditions such as psychosomatic pain or poisoning by coffee, tea or tobacco. A careful, accurate and painstaking history, plus the related physical signs, indicated laboratory procedures, electrocardiograms, and, when necessary, the use of the "anoxemia" or "two step" test, should render differential diagnosis relatively easy.

With the passage of years and the accumulation of medical experience based on improved diagnostic and therapeutic concepts the profession has come to alter its belief regarding the prognosis of coronary artery disease. This is particularly true regarding acute coronary artery occlusion. Some 25 years ago it was more or less generally believed that the majority of patients succumbed immediately or soon after the acute attack. Gradually through the years studies have appeared to indicate that not all patients with acute myocardial infarction are destined to die, but that many recover, and some even sufficiently to resume active participation in life. White's⁷ recent follow-up study on 497 cases of coronary artery disease indicates an average duration of life after onset of symptoms of 9 years instead of the classic and oft-quoted average of 5 years or less.

MANAGEMENT

Certain general measures are advisable in the successful management of angina pectoris. Of these, adequate rest is of paramount importance. In addition, strict limitation of physical effort below the level at which substernal distress or dyspnea is produced must be observed. Since excitement, worry, and emotional strain of all sorts tend to induce anginal seizures, the patient must be cautioned to avoid, when possible, situations which result in emotional strain, as well as other situations which tend to bring on his pain. A word of caution, perhaps, should be interposed at this point in regard to the mental attitude of the patient. With the present-day emphasis on the psychosomatic aspects of organic disease, one must guard against over-emphasizing restrictions to a degree where the cardiac patient tends to develop a state of chronic, and frequently unjustified, disability and invalidism.

The consensus seems to indicate that tobacco should be avoided or at least markedly restricted. However, alcohol in medicinal doses apparently is of benefit in promoting vasodilatation. The value of nitroglycerin, amyl nitrite, and trichlorethylene in alleviating the acute seizures of anginal pain is universally known and needs no further elaboration. The xanthine derivatives have been widely used in routine practice and good results reported in a large number of cases. There is, however, by no means universal agreement as to the relative merits of the members of this group. Levy and his associates⁸ have shown, however, in a group of patients taking large doses of aminophylline that a longer period of anoxia is required to produce subjective symptoms and electrocardiographic signs of coronary insufficiency than in patients not receiving the drug. On the basis of this study, they have found aminophylline to be a more efficient "vasodilator" than other members of the xanthine group. Since many patients with anginal symptoms are nervous and high-strung, mild sedative agents, such as

small doses of barbiturates or bromides one or more times daily, are valuable in producing a lowered tension in the nervous system. There seems to be little basis from the standpoint of clinical results as far as the use of tissue extracts is concerned. Further, although the favorable action of testosterone propionate in relieving the symptoms of angina pectoris has been reported by some investigators, others have been unable to notice that it has any beneficial effect.

In the hands of a few the surgical treatment of angina pectoris has been highly praised. Earlier procedures, such as cervical sympathectomy and, more recently, total ablation of the thyroid, have gradually lost their appeal. Operative procedures based on an effort to promote collateral circulation to the myocardium by the use of adjacent normal tissue transplants, such as muscle or omentum, are still in their experimental phase, and must be received with caution.

Like the symptom-complex of the condition, the management of acute myocardial infarction on the basis of coronary artery occlusion is well established in so far as the treatment of shock, anoxemia, relief of pain, and the treatment of resultant congestive heart failure is concerned. Of greatest importance, however, is the question of rest. There seems to be universal agreement on a period of absolute bed rest following the acute accident, of some 4 to 6 weeks, but it is in the subsequent management of these patients that there is a wide variance in practice. Recently there has been a tendency to condemn prolonged recumbency and inactivity after acute myocardial infarction for a period longer than 2 or 3 weeks. Those sponsoring this concept advocate the gradual return of the patient to his normal activities, with the plea that increased restraint leads such patients to exaggerate the seriousness of their physical condition, which may result in the development of a postinfarctional cardiac neurosis.

The important factor in this regard is pro-

viding adequate time and conditions for collateral myocardial circulation to develop, and the indications are that this requires many months for its accomplishment. If, therefore, this rationale is followed, the patient should not be allowed to resume work for several months, and in some instances for 1 or 2 years, although he may be allowed up 8 to 10 hours daily and allowed to walk in moderation if no distress results. He should, however, be forbidden to resume business responsibilities, except in the most minor degrees, during that time. White⁷ has aptly stated the importance of this rationale in the following paragraph, "A very important by-product of our follow-up study is the conviction, previously little more than a suspicion, that coronary heart disease, whether shown by the angina pectoris of temporary coronary insufficiency or by the myocardial infarction with subsequent scarring, is actually in major part, and in the majority of cases, an acute or subacute rather than a chronic disease, although frequently with recurrence. The coronary artery damage may be permanent, and therefore chronic, but its effect on the heart itself is the important point. It is the natural tendency of the heart to establish an adequate collateral coronary circulation that is the answer. Special care over the periods of the acute and subacute phases of coronary heart disease, replacing the old fatalistic point of view, is the most important point in the treatment of coronary heart disease, at times lost to view in the course of the introduction of new therapeutic measures."

SUMMARY

In summary, then, the incidence of coronary artery disease is high, and from all indications continues to increase. Since our ability to control the progress of coronary arteriosclerosis is inseparably linked to the still unknown etiology of arteriosclerosis in general, earlier recognition of the disease through the application of newer diagnostic procedures and careful, thoughtful management of each individual case offer our greatest hope toward a more optimistic future for patients with coronary artery disease.

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DIABETES TOMORROW*†

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ANY consideration of the future for diabetes must be based upon the startling increase in the number of diabetics in the population. Three causative factors are clearly evident: (1) more intensive search for and discovery of cases by better methods, (2) the aging of the population, and (3) the prolongation of diabetic lives due to better treatment.

The outstanding change in the statistics of diabetes, which has come about through the use of insulin, is the fact that the average age of death among 7,222 fatal cases has risen from 44 to 64 years. This clearly means the abolition of death in young diabetic patients but also it means increased duration of life after the onset of diabetes. Indeed, among this same group of fatal cases, the average duration of life has increased from 4.9 years in the early years of this century to 13.7 years between 1940-1944. Now the expectation of life for a 10-year-old child developing diabetes, based upon both fatal and living cases as calculated by the Metropolitan Life Insurance Company, is 40 years. Prior to 1914 only 2 patients in 100 lived for 20 years with diabetes; now such patients are 10 times as frequent. The doctor who treats diabetes today, therefore, must plan his treatment not merely for tomorrow, but for 20 years hence.

More significant still has been the discovery

of an unexpectedly high incidence of diabetes in the selectees examined at the Induction Center in Boston. Dr. Blotner and Dr. Hyde found that among 45,650 Massachusetts selectees who were examined not merely by question and answer but by analyses of blood and urine, diabetes in this age group was from 3 to 5 times as frequent as it had been expected on the basis of the National Health Survey. If these figures are confirmed in other parts of the country and particularly if such careful examinations were really carried out in the older age groups, then the total number of diabetics in this country might really prove to be not 700,000 but 2,000,000.

JUVENILE DIABETES

Formerly diabetes beginning before the age of 15 years was fatal in less than 2 years. Now with insulin such patients live long. Actually among 1,657 children seen and treatment begun since the discovery of insulin in 1922, only 137 have died. Nevertheless, the causes of death in diabetic children show clearly the enemies of the future.

If a total of 187 deaths in patients whose diabetes began before the age of 15 years and whose deaths have occurred since the discovery of insulin be analyzed, certain outstanding changes will be apparent. In the first 7 years of this period 82 per cent of the deaths were due to diabetic coma, whereas the percentage of deaths in the last few years has fallen to only 18. Similarly, there has been a decline in tuberculosis

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so that actually in the last 6 years only 7 deaths from tuberculosis have occurred. On the other hand, a steady increase in the deaths from arteriosclerosis has occurred to such an extent that in 1942 and 1943 arteriosclerosis involving the kidneys and the coronary vessels has become the chief cause of death. It must be emphasized that these deaths have occurred in patients whose diabetes has lasted some 10 to 20 years. Therefore the deaths have occurred at ages varying from 25 to 35 years. In general, the young patients who developed hypertension and albuminuria and then either coronary artery disease or nephritis have been those in whose cases the most conspicuous lack of dietary control has been present. Time and again these patients, as they developed retinitis or hypertension, have said, "Doctor, I never have followed my diet although I always took my insulin." Hyperglycemia, glycosuria and frequent attacks of acidosis have been outstanding features in this group.

Diabetes uncontrolled leads to coma or arteriosclerosis in the young.

The definition of the control of diabetes is far easier than the achievement of control. Unfortunately, we know so little about the intermediary metabolism of carbohydrate that we are forced to use as guides certain blood and urine tests without a full understanding of what steps may have preceded them. Nevertheless, one may say that the control of diabetes requires the normal utilization of a diet adequate in calories, in proportion to carbohydrate, protein and fat, in vitamins and mineral content. Guides in attaining control are (1) normal blood sugar values before meals; (2) the urine sugar free or glycosuria not to exceed 10 per cent of the dietary carbohydrate; (3) normal growth and development; (4) normal blood cholesterol levels; and (5) accurate observations of prescribed diet. Insulin must be given early in the course of juvenile diabetes and continued. There is no such thing as proper treatment of juvenile diabetes without insulin.

PREGNANCY IN DIABETES

The extraordinary improvement in the results of treatment of diabetic tuberculosis with the use of insulin was dramatic, but even more striking has been the change in the status of the pregnant diabetic woman. Prior to the use of insulin, menstruation usually ceased in diabetic women, and pregnancy was a rarity except in those essentially mild cases. Actually, Bouchardat in 1875 stated he had never seen a pregnant diabetic woman. With the discovery of insulin, pregnancy not only became more frequent, but the danger of acidosis in the mother dwindled. During the last 8 years, among 178 diabetic pregnancies under the medical supervision of Priscilla White, only 1 mother died and her death occurred 6 weeks after delivery from a cause not determined with certainty even after postmortem examination. There still remains the problem of miscarriage and fetal death. Prior to 1936 the proportion of children of diabetic mothers born alive was only 55 per cent, and it became clear that the cause for these toxemias with hypertension, albuminuria and fetal death was an imbalance of sex hormones. When this imbalance was corrected, fetal survival rose to 96 per cent. At present medical treatment of diabetic pregnancies may be summarized under three heads:

1. Diabetic treatment consists of a diet providing for carbohydrate 200 grams, protein 2 grams per kilogram, fat in sufficient quantity to give 30 calories per kilogram. Insulin is given, protamine zinc and crystalline, before breakfast. Supplementary doses of crystalline insulin at noon and night are given for patients requiring a total of more than 50 to 60 units a day.

2. Obstetrical management includes delivery in the 37th or 38th week under spinal anesthesia if cesarean delivery is needed.

3. Hormonal treatment consists of the use of estrin and progestin. A common daily

dosage is 15 milligrams of stilbestrol and 15 milligrams of proluton given intramuscularly.

The infant of the diabetic mother presents clinical problems due to the instability of regulation of respiration, of the blood sugar and the body temperature. Jaundice is not infrequent. Hyperplasia of the islands of Langerhans has been observed. Congenital anomaly is more frequent. Pregnancy in the diabetic mother has come to stay. In the future we must hope for proved methods of manufacture of hormonal substances such that the expense of hormonal treatment, now prohibitive, may be greatly reduced. Difficult decisions with regard to interruption of pregnancy will be more common.

ALLOXAN DIABETES

The discovery by Dunn in Glasgow of the effect produced by alloxan upon the islands of Langerhans provided an advance in our knowledge of diabetes comparable only with the discovery of Minkowski and von Mering and the later discoveries of Banting and Best, who gave insulin to the world in 1921. These two discoveries showed how to produce diabetes and that diabetes is essentially due to disease of the pancreas and insulin deficiency. The second method for producing diabetes was discovered through the efforts of Evans in the United States, Houssay in the Argentine Republic, and finally, of Young in England. The daily injections of extract of the anterior pituitary gland of the ox caused first temporary glycosuria and finally complete diabetes because of the destruction of the islands of Langerhans. Alloxan injection is the third and most rapid method of producing diabetes.

Alloxan, the ureide of mesoxalic acid, is related to the purines and particularly to uric acid, from which it can be produced by oxidation. In rabbits, rats and dogs injections of alloxan, either in a single injection of a large dose or by daily injections of smaller doses, will result very quickly, sometimes within a few hours, in the

production of necrosis of the islands of Langerhans. The first stage is characterized by low blood sugars in which the rabbits die of hypoglycemia unless they are treated with glucose. By giving glucose during these hours when the blood sugar is low, C. C. Bailey and O. Bailey kept the animals alive, and within a day or two diabetes was the result. At first it was thought possible that alloxan produced diabetes by stimulating the islands of Langerhans, with the result that low blood sugars were produced. It was thought also that perhaps the diabetes resulted from injury to other tissues. Actually, however, careful study of other tissues did not indicate that alloxan in the ordinary diabetes-producing dose has any serious injurious effect upon any tissues except the islands of Langerhans. Indeed, in a recent article, Rideout, Ham and Wrenshall, working with Professor C. H. Best have analyzed the insulin content of the pancreases of animals at various periods after the injection of alloxan. They found that the insulin content fell after the islet cells died. Their experiments indicated that alloxan causes hypoglycemia because it kills the islet cells and allows the insulin content to be leached out into the blood stream. Alloxan, therefore, provides us in a variety of animals with a rapidly produced diabetes of the pure pancreatic type. A remarkable opportunity, therefore, is available for studying the effects of treatment and of studying the methods of production of diabetic complications. Already it is evident that diabetic cataracts develop in rabbits and rats within 1 to 3 months. Diabetic coma developed in 1 rabbit when insulin was withheld. In this animal acetonuria and lipemia, with total blood lipids of 8,412 mg. per 100 c.c. and blood acetone value of 144 mg. were present. Alloxan attacks the center of diabetic pathology and again emphasizes the role of the islands of Langerhans not only in diabetes itself but in the characteristics of diabetic complications. Already the laboratories of Goldner and Gomori in Chicago and of those in other cities specially equipped

for investigating diabetes are studying alloxan diabetes. Whether alloxan occurs normally in the tissues of human beings, whether normally some substance inhibits its effect upon the islands of Langerhans and the absence of this substance results in human diabetes, and other intriguing problems will surely be unraveled in the future.

DIABETIC COMA

Diabetic coma is preventable and deaths are needless, but in the country as a whole diabetic coma continues to be a major cause of death. An analysis of 601 coma cases treated at the New England Deaconess Hospital between 1923 and 1944 has convinced us that it is the amount of insulin given in the first 3 hours of treatment which is of primary importance in determining the recovery or the death of the patient. Among 478 patients in coma treated at the Deaconess Hospital from 1923 to 1940, 12 per cent died. Often these presented severe complications, such as abscesses, carbuncles, and pneumonia. However, for 123 consecutive cases treated from 1940 to 1944, the death rate fell to 1.6 per cent. Indeed, the only 2 deaths were patients who were sent to the hospital from other hospitals in a moribund state many hours after the onset of coma. Actually those 2 deaths could have been prevented had earlier diagnosis and the earlier use of adequate doses of insulin been carried out. The most striking difference between these 2 series of patients, however, was the fact that in the early period of the use of insulin the first 50 cases received 83 units of insulin in the first 3 hours after admission to the hospital, and 18 per cent of that group died. In our recent group of 123 cases, when the mortality was only 1.6 per cent, the patients received 216 units in the first 3 hours. Diabetic coma is an emergency in which the patient's condition may change in 1 or 2 hours. The doctor's first duty, after making the diagnosis of coma, is to decide the question of how much insulin the patient needs, and for this decision he

must muster all his knowledge of the clinical course of diabetic coma as well as laboratory aid within the hour.

Granting that a careful search for complications has been made and that the diagnosis of diabetic coma has been confirmed by the finding of soft eyeballs, low blood pressure, low rectal temperature, dehydration, high blood sugar values and a reduction of the CO₂ content of the blood to 25 volumes per cent or less, what errors must be avoided? The most serious error is to give too little insulin. From table 1 it is clear that in our 123 cases 2 patients had blood sugar values between 1,300 and 1,600 milligrams.

TABLE 1

Blood Sugar Level Correlated with Insulin Dose in 123 Coma Cases

BLOOD SUGAR LEVEL ON ADMISSION (MG. PER 100 CC.)	NUMBER	AVERAGE INSULIN RE- QUIREMENT DURING FIRST 24 HOURS
1,300-1,600	2	1,224
1,000-1,300	15	815
600-1,000	26	387
400- 600	39	259
200- 400	51	162

They received 1,224 units in the first 24 hours and 800 units in the first 3 hours. In patients whose blood sugar was between 1,000 and 1,300 milligrams, 815 units of insulin was given in the first 24 hours. With lower blood sugar values the insulin requirement steadily fell. It is almost impossible to give too much insulin in the first 2 or 3 hours in a patient who is unconscious with true diabetic coma.

The second important error is the administration of glucose at the outset of diabetic treatment. In the last year we have seen in consultation or have reviewed the records of 15 patients who died in diabetic coma and who were treated by the administration of glucose solution in hospitals other than the Deaconess Hospital. Therefore, when we hear of a death from diabetic coma, the first question is, "Did that patient receive glucose solution intravenously, by mouth or subcutaneously?" The following case will serve as an example.

ILLUSTRATIVE CASE

A 12-year-old boy was discovered for the first time to have diabetes when he was in coma. He entered the hospital in the afternoon in a very drowsy state, became unconscious within a few hours and never regained consciousness. A complete autopsy was done but there were no significant pathologic findings.

Table 2 summarizes his treatment. The blood sugar was 475 mg. per 100 c.c. upon admission, and it was not determined later.

given every hour, and the child received a total of 770 units of insulin. The total amount of insulin given was more than adequate, but the tardy method of administration and the neutralization of the insulin action by the administration of 300 grams of glucose by needle and by stomach were the reasons for death. Had this boy been given 250 units within the first 2 hours of his admission, together with 1,500 c.c. of normal salt solution, recovery probably would have occurred. As it was, the urine never became sugar-free nor free from ketone bodies.

TABLE 2
Therapeutic Data of Illustrative Case

DATE	URINE: ACETONE SUGAR	INSULIN	REMARKS
		<i>units</i>	
4- 9-43	4:40 p.m. 2+/4+	50	1,000 c.c. 5% Glucose
	6:00 p.m. 2+/4+	50	
	6:30 p.m. 4+/4+	50	(stomach tube)
	7:00 p.m. 4+/4+	50	250 c.c. 10% Karo with NaCl gr. 45
	8:00 p.m. 4+/2+	50	7:30 8:00 8:30 9:00 9:30
	9:00 p.m. 4+/3+	50	
	10:00 p.m. 4+/4+	50	500 c.c. H ₂ O, regurgitated 100
	11:00 p.m. 2+/4+	30	1,000 c.c. 10% glucose with 2 ampules of Hartmann's at 10:15
		30	
	12:00 M.N. 2+/4+	30	500 c.c. Molar lactate i.v.
		30	
4-10-43	1:00 a.m. 1+/4+	30	(stomach tube)
		30	250 c.c. 10% Karo retained
	2:00 a.m. 1+/4+	30	250 c.c. H ₂ O regurgitated
		30	250 c.c. H ₂ O
	3:00 a.m. 1+/4+	30	250 c.c. H ₂ O
		30	250 c.c. H ₂ O
	4:00 a.m. ±/4+	30	250 c.c. H ₂ O
		30	250 c.c. H ₂ O
	5:00 a.m. 1+/4+	30	250 c.c. H ₂ O regurgitated
		30	250 c.c. H ₂ O
	6:00 a.m. ±/4+		
	Total	770 regular insulin	300 Gm. glucose 5,675 c.c. fluid including 2,500 c.c. intravenously

Discussion.—Upon admission, the patient received 50 units of insulin at 4:30 p.m. and 1,000 c.c. of 5 per cent glucose solution. No further treatment was given until 6:00 p.m., a clear indication that the physician in charge did not realize the emergency character of the situation and the rapid progression in the patient's condition.

At 6:30 p.m. a stomach tube was put down, obviously because the boy could not swallow. Karo corn syrup, consisting of 10 per cent glucose, was given through the stomach tube. It is also seen that Hartmann's solution was given intravenously.

The striking thing is that small doses of insulin were

The patient did not become anuric but merely died from faulty treatment.

The primary object in the treatment of severe diabetic coma is to bring about oxidation of glucose in order that it may take the place of fat in the metabolic mixture and so reduce the formation of ketone bodies. If the insulin dose is adequate, oxidation of the ketone bodies already formed undoubtedly will occur. If an adequate dose of insulin is given in diabetic coma, a rise in respiratory quotient will always be produced, because some oxidation of the excess glucose present in body fluids takes place, as well as deposition of the glycogen. The problem is to determine the dose of insulin needed,

because insulin resistance increases rapidly as acidosis advances, and the law of diminishing returns applies to the action of insulin, particularly in ketosis.

Circulatory collapse in coma is the result of hemoconcentration and dehydration. Its onset is hurried by the giving of glucose in water, and anuria is checked by the giving of salt in water.

DIABETIC GANGRENE

Diabetic clinics in the last 25 years have seen changes in the incidence, treatment and prognosis of diabetic gangrene from which clear indications of the diabetic future are apparent. The duration of life of diabetic patients has increased so rapidly during the period of the use of insulin that the problem of arteriosclerosis and lesions of the legs would be expected to increase, since so large a number of diabetic patients are now living far into the zone where vascular disease develops most easily. Yet an analysis of the cases operated upon for surgical lesions of the feet gives good reason to believe that the diabetic patient of the future need have less fear of gangrene than his brethren in the past, providing proper use is made of the methods of treatment now shown to be valuable.

TABLE 3
Diabetic Amputations

PERIOD	TOTAL NUMBER OF AMPUTATIONS	MAJOR THIGH	THIGH AMPUTATION MORTALITY %
1923-1929	160	106	19.8
1939-1942	230	107	11.2

In table 3 a comparison has been made of patients undergoing operation for amputation of toes or major amputation of the legs at the New England Deaconess Hospital in the period from 1923 to 1929 as compared with the period from 1939 to 1942. These periods were chosen because the number of major amputations of legs in the 2 periods were approximately the same, 106 and 107 respectively. The first striking change apparent on this chart is that in the period of 1923 to 1929, out of 160 total amputations 106 were of the leg, or two thirds of the amputations were major. In a later period,

on the other hand, only 107 out of 230 amputations were of the leg, or 43 per cent. This tendency, however, is far more advanced at present, since in the 12-month period ending July 1, 1944 amputations through metatarsals have begun to replace amputations above the knee. This type of surgery carried out in patients with diminished blood supply and infection has clearly been made possible through the use of penicillin. It has been given not merely intramuscularly but applied locally, and in this series of 18 cases thus treated by Dr. Francis D. Moore in 10 of the 18 the effect of penicillin has seemed decisive in controlling the infection and saving the patient from a major amputation.

The falling mortality in amputations of the leg has been apparent for many years at the Deaconess Hospital. In the years 1923 to 1929, mortality of major amputations was 19.8 per cent. In the second period the mortality for major amputations in 107 cases was 11.2 per cent. In 1942, in 43 major amputations, 4 deaths occurred, a mortality of 10 per cent, whereas in 1943 a single death among 42 amputations made a mortality of 2.5 per cent. No possible indication for a change to refrigeration is seen here. It is true that the use of sulfonamides during the last 2 or 3 years has contributed greatly to the reduction of the mortality, but with such a rapid change since the advent of penicillin who can foresee the mortality rate for major surgery of the legs in diabetic patients in the future?

For the diabetics of today, the question of operative procedure is of far less importance than the question of the prevention of gangrene. In this group two facts are outstanding in the occurrence of diabetic gangrene. The first is the lack of diabetic treatment and control of the diabetes during the years preceding gangrene, and the second is the lack of instruction of patients in methods of avoiding accidental injuries, burns, etc., and of treating lesions of the feet in their incipency. In the years from

1923 to 1929 the average duration of diabetes before the onset of gangrene was 8.6 years, and in that group only 4 patients had ever had insulin and they for periods so short that no possible preventive influence on the part of insulin could have been expected (table 4). In the

TABLE 4
Lack of Insulin Treatment Preceding Diabetic Amputations

PERIOD	CASES	DURATION OF DIABETES IN YEARS PRECEDING SURGERY	INSULIN THERAPY IN YEARS PRECEDING THIGH AMPUTATION
1923-1929	160	8.6	0
1939-1942	230	9.6	2.7*

* 39 cases out of 107 had never received insulin.

later period 39 cases out of a total of 107 had never received insulin, and the remainder, be it noted, had received insulin for an average of only 2.7 years, although their diabetes had been on the average 9.6 years in duration. Thus, on the average, those patients, like the patients in the earlier group, had had a period of 7 to 8 years of diabetes without insulin treatment. Let it not be thought, however, that the mere inauguration of insulin treatment without careful balancing of diet and insulin dosage is sufficient. Actually, if we analyze still further a more recent case series in 1943, we find that in the series of 43 cases for that year again 50 per cent of the patients had never had insulin, but, more important still for our thesis, of the 50 per cent who had received insulin only 1 of the series could be said to have adhered to his dietary instructions. Flagrant breaking of diet with lack of control of the diabetes and high blood sugar levels upon admission to the hospital characterize the past history of the diabetic patient who gets gangrene. In brief, one might say that in this group 7 years of mild diabetes, uncontrolled by the use of insulin or careful diet in a patient over 40 years of age, is the almost universal preparation for gangrene. In the future, use insulin early in diabetes to permit repair of the pancreas, to control glycosuria, and to prevent premature vascular disease.

FUNDS FOR DIABETES

For many years provision has been made for the campaign against tuberculosis, and each year large sums are gladly given to aid the campaign against infantile paralysis. Actually diabetes is as common as tuberculosis and probably from 5 to 10 times as common as poliomyelitis with residual paralysis. A diabetic fund should have as its objective promotion not only of formal scientific research by a few in highly specialized laboratories, but it should also in each community stimulate the research idea in the minds of doctors and patients alike, so that progressive improvement in the treatment of each individual patient may be brought about. The collection of statistical data in each community is needed to give further light on the incidence, the complications, the results of treatment, and the causes of death. In Philadelphia a particularly valuable service is being rendered by the Metabolic Society there in reporting causes of death each year. It is to be noted in the most recent report that the deaths from diabetic coma in that city have tended steadily to decline with each year. The purpose of the fund also should be to bring about the application of the best knowledge available for the control and treatment of diabetic patients in the community. This means improved instructions not only for students, physicians and nurses, but also for the patients and the community itself. Financial support would be obtainable for laboratories, emergency hospital beds, and children's camps.

Actually, only 4 such funds are known in the United States in addition to one national and five local diabetic societies. Support of such diabetic funds should and will come chiefly from diabetic patients themselves and from their relatives.

SUMMARY

1. In a series of 478 cases of coma observed

(Continued on page 101)

ELECTRIC CONVULSIVE THERAPY IN PSYCHONEUROSES*

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LECTRIC convulsive therapy is the newest and at present the most widely used form of the so-called shock methods in neuropsychiatry. Its extreme simplicity and the possibility of ambulatory application favor its use in that type of neuropsychiatric disorders which is most frequently encountered by the general practitioner, viz., in the neuroses. One of the reasons why many practicing physicians, whether psychiatrists or not, remain skeptical about the shock treatments is that the new methods have their best results in the acute psychotic reactions as mostly seen in institutions, but that they are of little value in the psychoneurotic patient who comes to the physician's office.

Electric shock treatment is in no way related to older electric treatments in which a stimulating or sometimes quieting effect, attributed to different types of currents, was produced. Such currents were applied in various ways, especially to neurotics, and they had a definite suggestive influence. In the last war use was made of painful faradic stimuli for conversion symptoms such as hysterical shaking or hysterical paralysis. The patients were "shocked," and in some of them the hysterical manifestations disappeared. This was a mechanism quite different from our present shock methods which have nothing shocking or frightening for the patient who, because of the amnesia connected with the treatment, is mostly unaware of its application. The curative agent in the modern electric shock treatment is not the current at all but the convulsion produced by the electric

stimulus. Such a convulsion was first produced with pharmacologic means such as intravenous injection of metrazol. Several inconvenient features of the metrazol method led Cerletti and Bini¹ in 1938 to replace the metrazol injection with a simpler and older way of stimulating the cerebral cortex, namely, the electric current.

Potential differences of 70-130 volts A.C. for 0.1 to 0.5 second are used. An automatic clock interrupter or time relays break the circuit after the desired time. The current passing between the electrodes is of the order of 200 to 1,000 or more M.A. Originally this very strong current caused serious objections because its passage through the heart might be fatal. Applying such current through the brain by means of 2 electrodes on the sides of the patient's temples, we obtain a generalized convulsion which has all the characteristics of an epileptic seizure. A convulsion is necessary for therapeutic results. By applying less current we may not obtain a convulsion but another response which should be avoided in electric shock treatment, i.e., mere unconsciousness. This effect is similar to the "petit mal" response in epileptics. When it occurs it is necessary to repeat with a higher voltage or with a longer time exposure until a convulsion is produced. We have treated a series of patients with only the petit mal response in order to avoid the crude effect of a generalized seizure. The poor results of this procedure compared with the good results of a subsequent course of convulsions in the same patients have shown that a generalized seizure is necessary for therapeutic purposes.

The evaluation of treatment procedures in

* Read at the Sixteenth Annual Scientific Assembly of the Society, October 5, 1944.

neurotics always meets with great difficulties and might be one of the reasons why even for psychoanalytic treatment, statistics on results are not yet available. Experience with shock treatment in neurotics can best be interpreted when compared with results of the same worker in psychotics. Therefore, it may be permitted to give a very brief survey of the results which I obtained in nearly 2,000 psychotics treated at the New York State Psychiatric Institute and in a large institution, the Pilgrim State Hospital.

That it is the acute psychotic who responds best was well illustrated by the fact that the best results were obtained in the institutional material, whereas results were much poorer in the Psychiatric Institute where we deal with voluntarily admitted patients and where, therefore, more borderline cases between neurosis and psychosis are treated. It was already known that with insulin treatment the chances for recovery in schizophrenia are considerably decreased by psychoneurotic features in the clinical picture of the psychosis. The same is true for electric shock treatment. Not only were my own results in such material of borderline cases poor, but the least satisfactory results on shock therapy come from the research centers because their material mostly does not contain the acute psychotics. It is in the material of mental institutions that we see the patients most suitable for electric shock therapy.

In order to demonstrate the possibilities of electric shock therapy in such cases I might mention a few figures from my institutional material. The excellent and often dramatic results in involutional depressions are best known and have contributed greatly toward giving electric convulsive therapy its great popularity. The same complete agreement exists regarding results in manic-depressive psychoses. Pure depressions can be treated successfully in the vast majority of cases. The figures for remissions vary between 80 and 100 per cent, our own figures being nearly 90 per cent. In acute manic excitements of the manic-depressive psychosis our results are almost as good, except that

manics have to be treated more intensely, preferably with daily treatments or even 2 treatments a day. Six to 8 treatments are usually sufficient in both types of manic-depressives. Here we first encounter the interesting fact that poorer results are obtained in borderline cases between neurosis and manic-depressive psychosis. By this we mean patients who show neurotic symptoms of various types but whose neurosis is accompanied by depressive features, or, more seldom, by periods of a manic-like overactivity and irritability. These patients are sometimes classified as psychoneurotics, sometimes as cyclothymics. They do not go into an acute psychosis and are found in private practice rather than in institutions. Their response to convulsive therapy never shows the convincing results we see in frank psychotics.

Exactly the same can be said for borderline cases between psychoneurosis and schizophrenia. Those schizophrenics who do not show acute psychotic symptoms and in whom the personality remains pretty well preserved while anxiety or bizarre obsessive-compulsive ideas are in the foreground, show the poorest response to treatment. On the other hand, in a group of 275 clearcut institutional schizophrenics² with acute symptomatology, excluding all borderline cases, we obtained 68.3 per cent remissions in cases of less than 6 months' duration, 41.5 per cent in cases of 6 months' to 2 years' duration, and as little as 9.2 per cent in cases of more than 2 years' duration. Such results are not obtainable with as few as 4 or 5 treatments, after which the patient usually becomes symptom-free but will relapse as soon as treatment is discontinued. In our experience 20 to 30 treatments are necessary for permanent results with electric convulsive therapy in schizophrenia, and the failure to continue treatment sufficiently long explains the frequent statement that schizophrenics do not respond lastingly to convulsive therapy. This insistent continuation of treatment, however, does not lead to any better results in the much less severe border-

line cases between psychoneurosis and schizophrenia. Their response is different from the start because they do not show the surprisingly constant initial response which frank psychotics show after 4 applications. Cases with neurotic features might be temporarily more relaxed during the treatment, but usually they do not reach a convincing recovery from their symptoms at any time. Statements about percentage of remissions under shock treatment are misleading as long as the type of material is not specified. This was well illustrated by my personal simultaneous experience in the two hospitals with poorer results in the hospitals where acute and disturbed patients are not admitted and where the percentage of borderline cases is very high.

It was in accordance with these experiences that we were doubtful when the first reports were published regarding the use of electric convulsive therapy in pure neurotics. Conflicting reports on electric convulsive therapy in neurotics gave rise to a project at the Psychiatric Institute to treat a larger group of psychoneurotics in order to establish in what type of neurotics such treatment is actually indicated. A first group of 65 patients was reported on.³ In the meantime some more cases in the hospital, as well as in private practice, permit the presentation of the following data.

The various types of psychoneurotics are discussed separately, although it is fully realized that most psychoneurotics are "mixed" in their symptomatology, with one set of symptoms usually predominating.

The most frequently encountered symptom in neurotics is anxiety and the group of anxiety-hysteria should be discussed first. It is the group least amenable to electric convulsive therapy. Most patients remain unimproved during the entire course; many become worse and were aggravated by the fear of the treatment. Only a few become temporarily relaxed and less tense, but even these usually relapse shortly after the treatment.

The group of conversion hysteria gave equally unsatisfactory results in our material. Hysterical symptoms may occasionally be influenced as they are by any suggestive method. Frequently, however, new symptoms are produced by the treatment. The slight but frequent side-effects of electric convulsive treatment such as muscular pain, dizziness, memory impairment and others are elaborated on by hysterics and may aggravate severely the patient's condition. This makes shock treatment in hysterics rather hazardous. The few improved cases we had were either patients who had seen and were greatly impressed by improvements in psychotics or those in whom conversion symptoms were accompanied by and probably expression of a depression. Psychoneurotic depressions show the best results. Although the neurotic symptoms usually remain uninfluenced, the depressive features in these patients clear up after as few as 4 or sometimes 5 treatments. The euphoric reaction which often follows the treatment gives these patients a strong impulse to resume their former interests and relations. This is the only group of psychoneurotics in which the convulsive treatment is definitely superior to psychologic methods and should be tried in every patient.

In the obsessive-compulsive group our results were ambiguous. A small group of patients benefited lastingly from the treatment, but a larger number failed to show any lasting improvement. A dramatic disappearance of symptoms as seen in psychotics was never experienced in this group. However, many patients would lose their tension and the strong emotional response to their obsessive-compulsive symptoms. The obsessions might continue, but they would not bother the patient so much and he would feel more at ease. When treatment was continued up to 15 or 20 applications these patients lost all recollection of their compulsions and obsessions, but closer examination showed that this was only part of a general amnesic syndrome which not only let them forget their symptoms but also many life experiences. This

became obvious after the discontinuation of treatment when in most instances the obsessions reappeared together with the clearing up of the memory impairment. However, some patients were favorably influenced by psychotherapy during the period of diminished tension and became more interested in their personal and professional life. In some, the obsessive-compulsive symptoms disappeared lastingly, and these few cases justify the treatment in those obsessive-compulsives who could not be influenced otherwise, or in whom a relationship to one of the psychotic groups could be expected.

A few remarks should be made regarding the relationship of electric convulsive therapy to other organic treatments in neurotics. Metrazol convulsive treatment in neurotics was first used by Shapiro and Freeman⁴ with encouraging results, but did not justify early expectations. Also insulin treatment in pre-comatose doses was tried with some sedative effect. The best results, however, of all organic treatments in neurotics were described by Freeman and Watts in their studies on prefrontal lobotomy. This operation and electric convulsive therapy both interfere with brain function, but the effect of convulsive treatment in neurotics is largely transitory and sometimes of less value, whereas frontal lobotomy produces a permanent blanching of the emotional coloring connected with the obsessive ideas. We had the opportunity to see this superiority of the operative procedure for obsessive-compulsives in one of our patients who lost his symptoms temporarily under 20 electric shock treatments, but lastingly, only after prefrontal lobotomy, although the character changes after the operation were quite pronounced. In spite of this difference the small risk and the good results in at least a small number of cases justify an attempt with electric convulsive therapy prior to the operation. We would like to emphasize again that what has been said here about the transitory effect of electric convulsive therapy is valid only for the psychoneuroses.

Studying the effect of electric convulsive

therapy in all types of neuropsychiatric disorders, we realized more and more that we have two different types of reactions, one being the sudden disappearance of psychotic symptoms for which we have no explanation and which actually is as empirical today as it was 10 years ago when the first convulsive method was introduced. This type of sudden improvement is seen in most successfully treated depressives, catatonics and other psychotics. The second type of improvement occurring more slowly during the treatment is due to symptoms which have to be considered as side-effects of electric convulsive therapy. Their main expressions are the unpleasant-memory impairment and even transitory confusional states of Korsakoff type which make the patient simply forget his symptoms. Others lie in the emotional sphere and consist of flattening of affect, loss of tension, euphoria and other symptoms which occur in all types of organic interference with brain function, e.g., in infections and intoxications. These emotional changes usually are pleasant for the patient and account for remarks to the effect that he "feels at ease as never before" or that he is "happy for the first time in his life." Other patients, however, complain of these symptoms because they are frightened by "feeling differently" and are afraid of "losing control" of themselves. Those who enjoy the feeling of ease are more frequent, but it must be realized that the euphoria and slight blurring of consciousness are temporary side-effects, and that such improvement will be short-lived. The same is true for obsessive-compulsives who, with many other memories, may forget their obsessions. Such transient improvements are not comparable to the observations in successfully treated psychotics. Here, psychotic experiences are suddenly cut out, and when the memory of them returns the patient recognizes them as phantasies or ridicules them. Such real cures which we do see again and again in psychotics hardly ever occur in the psychoneurotic patient, with the exception of psychoneurotic depressions. It is doubtful whether these are not depressions of

the same type as manic-depressive or involutional depressions, with the only difference that they occur in a neurotic setting. This concept is backed by the fact that the patients usually remain neurotic and that only the depression disappears under the treatment.

Different types of results determine our decisions as to the number of treatments advisable in different patients. The optimal number of treatments, well determined in our experience for the various major psychoses, cannot easily be given for the neuroses. In patients whose treatment is mainly intended to relieve tension and to overcome resistance against psychotherapy, few treatments with longer intervals and avoidance of confusional states are preferable. In depressive syndromes the optimum will be 5 to 8 treatments as given in other depressions. In obsessive-compulsives 20 treatments are considered by us as a minimum as in schizophrenics because of the possibility of relationship of such cases to schizophrenics.

The question whether shock therapy should be combined with psychotherapy in order to achieve results plays an important part in all discussions on the new treatments. In psychotics our experience led to the definite opinion that psychotherapy is not more important than in any physical illness in which some psychotherapy will be performed by an understanding physician but no formal psychotherapy is necessary. A comparison between my own series in the Psychiatric Institute where all patients had a second physician discussing their problems with them, and in the Pilgrim State Hospital where no psychotherapy was applied during the treatment shows that results were superior in this latter group. In the psychoneuroses the opposite is true. We believe definitely that psychotherapy not only remains the treatment of choice in neurotics but that when shock therapy is applied, it should be accompanied by psychotherapy during and after the shock treatment. In our favorable cases

we felt that both had to be given equal credit. The better psychotherapeutic accessibility during and after electric convulsive treatment can be used successfully by the psychotherapist.

Cerletti, the originator of electric convulsive therapy, was the first to try the method in a few severe cases of psychoneurosis without, however, seeing more than transient results which he attributed to autosuggestion. Many experienced investigators reported discouraging results, or even warned against its use in neurotics. Others recommended it and found a rather high rate of improvements. However, it is frequently overlooked that the figures are also far higher than usually realized for neurotics treated with psychotherapy. In most statistics they range between 60 and 70 per cent, when greatly improved and slightly improved cases are taken together. Our results in electric convulsive therapy reach these figures only in some types of neurotics.

A discussion about electric convulsive therapy in the psychoneuroses must include also the risk involved in such treatment. The complications of convulsive therapy have found somewhat exaggerated attention. On the basis of our large material on psychotics we can state that they are negligible considering the seriousness of the illnesses we are treating. The situation is different when we deal with a group of disorders like the psychoneuroses for which other treatments are available.

In our material of 2,000 cases no fatalities occurred. Medical conditions like cardiovascular disease, diabetes and tuberculosis were never aggravated by the treatment. This was not unexpected since there is no evidence that in epileptics the occurrence of seizures aggravate such general conditions. We might also mention that several pregnant women were treated without complications for either mother or child.

Our main problem is the occurrence of fractures. Those of the vertebrae have been overemphasized. They rarely produce more clinical

signs than back pain of short duration. However, when we treat psychoneurotics, this pain can lead to an extremely unpleasant situation for the patient, and certainly for the doctor as well. There is no other group of patients in which we are apt to encounter such a persistence of this pain as in neurotics. In my own experience it so happened that by far the most pronounced compression fracture I ever saw occurred in a case of conversion hysteria. Fractures of the long bones can mainly be avoided by not using too tight a restraint. Except for the very first cases in my experience I did not see any fractures in the younger age groups which comprise most of the psychoneurotics we treat. In elderly patients it is more difficult to avoid an occasional fracture. We do not use curare routinely; it prevents fractures but seems to increase the risk inherent in the treatment. I would like to repeat that fractures are so rare that their possible occurrence should certainly not lead the physician to withhold treatment in psychotics; but they should be definitely taken into consideration when we decide about the method of treatment in a neurotic.

We have already mentioned the unpleasant side-effect of confusional states. They sometimes are particularly unpleasant in neurotics, but they are always transient. They may become a diagnostic problem when a neurotic patient toward the end of a long course of treatments goes into a delirium-like condition and presents delusions and hallucinations. The mistake is not infrequently made to change the diagnosis of such cases from psychoneurosis to schizophrenia. There will always be disorientation and other organic signs which permit recognition of such episodes as organic reactions due to the treatment. They will disappear within 1 week after the treatment. It is interesting to note that we saw several neurotics of pycnic type react with manic-like

conditions, while the asthenic neurotic with schizoid personality is more apt to show schizophrenic-like symptoms during the confusional state.

CONCLUSIONS

The practical conclusions regarding the value of electric convulsive therapy in the psychoneuroses are less definite than they are in the psychoses. In our own experience on an unusually large number of psychotics the value of the new treatment is beyond doubt. In manic-depressives and involutional depressions favorable results can be achieved in the vast majority of cases. Results are still gratifying in schizophrenics with acute symptomatology for whom the importance of early and adequate treatment has to be stressed emphatically. No similar results are seen in any of the psychoneurotic groups except for depressions in which electric convulsive therapy should be definitely applied in all cases. Results are poor in anxiety neurosis and in conversion hysteria, and here it should be used only reluctantly because these patients might react to the treatment experience with new or aggravated symptoms. However, tension can be relieved temporarily and the psychotherapeutic approach facilitated. Obsessive-compulsive neurotics react favorably in a small number of cases, and the treatment may be tried when the patient's resistance to psychotherapy cannot be overcome otherwise. The fact that neurotic symptoms are sometimes the clinical expression of a psychosis also justifies occasional attempts in such cases with diagnostic problems. As a whole, results with electric convulsive therapy in psychoneurotics are unsatisfactory. The selection of suitable cases requires considerably more experience in the neuroses than it does in the psychoses. Only a very critical use of electric convulsive therapy in the psychoneuroses will yield good results.

(Continued on page 102)

MAXILLOFACIAL INJURIES^{*†}

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DURING times of peace maxillo-facial injuries are by-products of automobile accidents and occasionally are of occupational origin. War, however, decreases these slightly but makes a very major contribution of its own in the form of bullet and shrapnel wounds. In many instances the results are similar; soft tissues suffer abrasions, cuts, lacerations and puncture injuries, and underlying bone is fractured and sometimes comminuted.

TREATMENT OF WOUNDS OF **I**SOFT TISSUES

Traumatic injury about the face can cause fracture and displacement of osseous structures with or without contusions and lacerations of the soft tissues. Early treatment of both is generally of great value, but particularly is this true of soft tissue, in which removal of foreign bodies and causes of pigmentation, necessary débridement, and early subcutaneous suturing are of inestimable value.

Complete cleansing is imperative and explains success in many instances. The retention of minute metal fragments, paint or deep stains from abrasions caused by scraping the skin surface on cement or other rough surfaces generally cause permanent discoloration. Where conditions permit, thorough scrubbing of soiled tissue is definitely indicated.

Even after every precaution has been taken, the probability of infection exists and when present as a complication adds much to tissue

loss and subsequent disfigurement. Penicillin has been used to advantage in this field in two ways, first, prophylactically for a period of 5 to 7 days to prevent infection, and second, for 10 days or longer to control an existing infection. Topically, it is used in wounds in a vehicle of sulfanilamide, 10,000 units to the gram, or in blood plasma, 20,000 units to the gram.

Superficial suturing immediately after injury for control of hemorrhage without toilet of the wound is a temporary expedient and needs to be followed as quickly as possible by meticulous care, which will insure, after thorough cleansing, proper approximation of skin edges. Tears which involve the lips need special attention to insure regularity of the vermilion border. An irregular lip which shows a patch of mucous membrane extending into epithelium is a constant source of discomfort to the patient esthetically, and implies an inexact technic. To avoid this, if in the early part of lip repair an initial suture which accurately approximates the parts is placed directly in the line of the vermilion border, one can be reasonably certain that the end result will be correct. Deep injuries which extend to underlying bone, if closed in layers by suturing the muscle fascia rather than muscle itself, followed by skin approximation, do well. The insertion of a small rubber drain at the dependent end of the wound still stands as a valuable precautionary measure against damaging edema and loss of sutures, in the event of the development of infection.

FRACTURE OF FACIAL BONES

Among the more common sites of injury of the bones of the face are the zygomatic arches.

* "The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large."—Art. 113 (2), U. S. Navy Regulations.

† Read at the Sixteenth Annual Scientific Assembly of the Society, October 5, 1944.

the orbital arches and the malar process, the nasal spine, and the maxillary bones.

Blows on the side of the head sometimes cause a depressed fracture of the zygomatic arches. This is readily elevated by the Gillies' method of passing a rigid instrument under the break through a skin incision slightly above the hairline. Correction restores facial symmetry.

The orbital arches may be severely comminuted, and if the injury involves the orbital floor, a visual disturbance in the form of diplopia usually is present. Treatment consists of digital manipulation to restore a regular outline, but in the case of downward displacement of the floor, a head cap with elastic traction is useful to pull it upward into position; similar traction may be required to overcome malposition of the malar process.

Fracture of the nasal spine is frequently reduced by applying intranasal pressure under the fragments; this is preceded by topical anesthesia of the nasal mucous membrane. Of the facial bones, the maxilla is second only to the mandible in frequency of injuries. Fracture of the alveolar process is common with displacement of teeth, but horizontal fracture with movement backward or laterally is not unusual. When this occurs an extraoral device capable of powerful traction is needed to bring the displaced parts forward into position.

The usual route of such a fracture is on the level of the antral and nasal floor and sometimes slightly higher. When traction has reestablished occlusion of the teeth, intermaxillary elastic

traction is applied to prevent any change of position until healing has occurred.

Simple fracture of the dentulous mandible is managed with arch bars or buttons, to which elastic traction is applied for immobilization while healing. Edentulous mandibles, however, present a different problem, particularly if the break is at the angle and, more particularly, if chronic non-union and malposition obtains because of unsuccessful treatment.

A valuable approach in these conditions is the open operation which permits a clear view of the entire field. By this means, old scar tissue is cut away, round bone ends are freshened, and direct wiring is done to hold the parts in position. If further stabilization is required, a plate of tantalum can be fitted over the inferior border. In the event of extensive loss of cortical bone a gap of as much as 5 cm. can be bridged by this method.

SUMMARY

Early treatment of maxillofacial injuries is beneficial. If bony parts are displaced, gradual elastic traction is useful to pull them back into position.

Soft tissue lacerations require thorough cleansing and, if deep, should be closed in layers.

Penicillin therapy is proving of value in preventing and controlling infection but must be accompanied with adequate surgical drainage. The open operation is frequently the method of choice in chronic fracture of the edentulous mandible.

President's Page

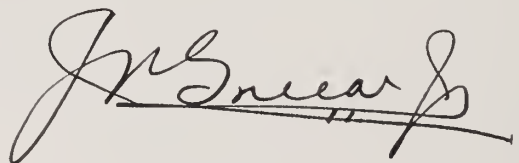
WHAT OUR MEMBERS THINK

One of the things which has disturbed me since I became President has been the discovery that many physicians have little knowledge of social trends in this country and their probable effect upon medicine. It was this that prompted me to address a letter to the membership of the Society late in December stating my concern lest our physicians fail to recognize the problems that must be met. You will recall that I said, "There is an undeniable need for a modification of the present methods of providing medical care and unless the medical profession realizes this and acts accordingly, it will, in my opinion, deserve what comes its way. For let me assert most emphatically that a negative attitude will spell disaster for the medical profession." I urged the membership to support a plan soon to be submitted by the Society's Committee on Medical Care. Furthermore, I cautioned our physicians not to take the present war prosperity too much for granted, that it can't last. And that upon the return of our service physicians there will be keener competition than we knew even in the prewar era.

I sincerely hope those members who have not read my letter will do so. Naturally, I am anxious to learn your reaction to it. Letters and telephone calls which I have received to date have been favorable. Some have talked with the Secretary of the Society voicing their approval.

You may be interested in what those who wrote me had to say. One said: "If there had been a little more of your attitude and a little less stand-pattism in the medical profession, we would not now be in the unpleasant situation in which we find ourselves." Another, "The letter . . . was splendid. If we keep hammering away we will get results." A serviceman expressed himself as follows: "Although I am quite in sympathy with our overworked and fatigued colleagues back home, I am apprehensive lest they delay too long in the promulgation of our plans for affordable fee private practice whether it be by prepayment or other plans. I pray that a suitable solution will soon be forthcoming." Just one or two more comments—"An excellent letter! I hope it is taken to heart by the active membership." And, "This is just to express my warm approval of the manner in which you face the problems confronting our profession."

As I have said, I have had no adverse comments. There may be those who do not see eye to eye with me. I will welcome their letters as I have those who support my views. However, I have a deep conviction that I am right and I trust that the medical profession will agree with me.

A handwritten signature in dark ink, appearing to read "J. M. Smead". The signature is fluid and cursive, with a long horizontal stroke extending from the end of the name.

Editorials

SOUND PLANNING FOR COMMUNITY HEALTH

The coming health and hospital survey of the metropolitan area of Washington proposed by the Washington Metropolitan Health Council should lead to a progressive, forward-looking development of health and sickness facilities throughout the area. It should have the endorsement of every citizen interested in sound planning for the health of the community.

The Health Council itself is a development of the Health Division of the Council of Social Agencies of the District of Columbia and Vicinity. The Division has set up within itself a strong Coördinating Council of prominent and influential citizens and has taken a new name, "Washington Metropolitan Health Council; a Division of the Council of Social Agencies of the District of Columbia and Vicinity."

During the process of its reorganization the Health Council addressed itself first toward setting up the survey mentioned above with the idea that it is already late enough to begin planning for the immediate and distant future of this metropolitan community. An over-all understanding is needed of what gaps exist and where there may be overlapping, duplication and waste of resources. With such an over-all picture it may be possible to judge the fitness or unfitness of proposals which emanate from time to time from various sources. A new facility which is not needed should not be built, but one which is needed should be erected. A facility which exists and is needed and is obsolete and costly should be replaced. Overlapping jurisdiction and duplicate efforts in the same field should be clarified. The public is interested in the economic operation of necessary facilities and the public pays the bill, either

through taxes, through voluntary contribution, or in other direct payments to facilities.

The coming survey should not result merely in a new volume of facts and recommendations which might make interesting reading. There have been previous surveys here which have accomplished some good and which are available for reference now. Some of the recommendations made in previous surveys have been carried out and others, it is regrettable to observe, have not been realized. One principal difference in the proposed survey and others which have been made in Washington is that the present one has the support not only of the Council of Social Agencies, but of a strong Coördinating Council. The Council, it is confidently expected, will follow through on the recommendations agreed upon.

That there is public interest in the survey is evidenced by the fact that up to the time of going to press with this editorial the Board of Directors of the Council of Social Agencies has approved it, also the Public Health Committee and the Board of Directors of the Washington Board of Trade. Two leading Washington newspapers have editorially endorsed the survey.

In setting up its organization the Health Council has provided a mechanism for the continuance of its coördinating body so that it may hope to take its place and maintain itself among the health councils of other cities.*

The Medical Society has two official designees to the Health Council, Dr. William P. Herbst and Dr. Henry C. Macatee. The Health Council has appointed to its Coördinating Council Dr. Frank D. Costenbader and Mr. Theodore Wiprud.

* Editorial: M. Ann. District of Columbia, 1944, 13, 381.

An idea of the make-up of the Coördinating Council of the Health Council may be gleaned from its roster which appears below:

Dr. Herbert P. Ramsey, *Chairman*; Randolph G. Bishop, Executive Secretary, National Dental Hygiene Association, and Howard Strong, Executive Secretary, Health Advisory Council, Chamber of Commerce of the United States, *Vice Chairmen*; Mrs. Warren Barbour; Dr. Ralph Beachley, Health Officer, Arlington County; Miss Fdith Beattie, Executive Secretary, Graduate Nurses' Association; Mr. D. C. Book, former Chairman, Alexandria Community Chest; Mrs. William Carter Bowles, Member, Public Health Lay Council, Montgomery County; Miss Gertrude Bowling, Executive Secretary, Instructive Visiting Nurse Society; Mr. Frederick M. Bradley, Attorney-at-law; Dr. John M. Byers, Health Officer, Prince Georges County; Mr. Edmund D. Campbell, Attorney-at-law; Dr. George B. Clendenin, Past President, District Dental Society; Mr. Barnum L. Colton, Vice President, National Savings and Trust Company; Dr. Frank D. Costenbader, Chairman, Committee on Medical Service, The Medical Society of the District of Columbia; Dr. Paul F. Douglass, President, American University; Mrs. Henry Grattan Doyle, President, Board of Education; Dr. V. L. Ellicott, Health Officer, Montgomery County; Mr. Ray H. Everett, Executive Secretary, Social Hygiene Society; Brig. General Leigh C. Fairbank, former Chief of Dental Corps, U. S. Army; Mr. William J. Flather, Chairman, Admissions and Budget Committee, Community War Fund; Mr. Edward K. Funkhouser, Executive Secretary, D. C. Tuberculosis Association; Rabbi Norman Gerstenfeld,

Washington Hebrew Congregation; Maj. General U. S. Grant III, Chairman, National Capital Park and Planning Commission; Dr. Ernest S. Griffith, President, Council of Social Agencies; Brig. General Frank T. Hines, Administrator, Veterans' Affairs; Dr. Vane M. Hoge, U. S. Public Health Service; Mrs. Reginald S. Huidekoper; Dr. Mordecai W. Johnson, President, Howard University; Mrs. Milton King; Maj. General George F. Lull, Deputy Surgeon General, U. S. Army; Vice Admiral Ross T. McIntire, Surgeon General of the Navy; Mr. B. M. McKelway, First Vice President, Board of Trade, and Associate Editor, *Evening Star*; Mrs. Eugene Meyer; Mr. Watson B. Miller, Assistant Administrator, Federal Security Agency; Dr. Winfred Overholser, Superintendent, St. Elizabeths Hospital; Dr. Nelson Podolnick, Health Officer, Fairfax County; Mr. Kenneth E. Pohlmann, Health Service Specialist, Farm Security Administration; Dr. George C. Ruhland, Health Officer, District of Columbia; Mrs. Francis Bowes Sayre; Mr. Ted Silvey, CIO; Monsignor Lawrence J. Shehan, Director, Catholic Charities; Mr. Willard Smith, Administrator, Health Security Administration; Mrs. Millard E. Tydings; Mr. Frank Waldrop, Assistant to the Editor and Publisher, *Washington Times-Herald*; Mr. Robert Watt, International Representative, American Federation of Labor; Mr. H. Mason Welch, Attorney-at-law; Dr. Garnet C. Wilkinson, Assistant Superintendent of Schools; Dr. Ralph C. Williams, Assistant Surgeon General, U. S. Public Health Service; Theodore Wiprud, Secretary, the Medical Society of the District of Columbia.

H. P. R.

THE DAVIDSON LECTURE

The eighth Davidson Lecture is to be given on October 17, 1945. Washington physicians and scientists who wish to compete for the privilege of being the lecturer on that occasion must observe the following rules:

"The selection of the Davidson Lecturer shall be on the basis of competition, the winning essay to be selected by a subcommittee consisting of five (5) members of the Executive Board appointed by the Chairman. No member can serve on the committee who may desire to compete.

"The competition shall be thrown open to

physicians or other scientists working in the District of Columbia.

"The essays to be submitted must bear no indication of the author's identity, being signed by a nom de plume. The identification of the author must be in a sealed envelope bearing on its surface the same nom de plume. No essay may be submitted that has been published.

"Essays should be submitted to the Secretary of the Medical Society of the District of Columbia not later than July 1 of odd numbered years.

"In case no essay is found worthy of an

award, the subcommittee shall declare no award; the lecturer then to be selected by the full Executive Board."

It is desired that wide publicity be given the contest so that all those who are eligible will be given an opportunity to participate.

The Chairman of the Subcommittee on the Davidson Lecture of the Executive Board is

Dr. William Earl Clark. Other members are Drs. A. Magruder MacDonald, Fred R. Sanderson, Henry R. Schreiber and Coursen B. Conklin.

Those who plan to compete are reminded that all essays must be in the hands of the Secretary of the Society not later than July 1, 1945 and that no manuscripts will be accepted after that date.

SOCIAL HYGIENE AND THE PHYSICIAN

Though venereal disease control probably is the most widely recognized objective of organized social hygiene, it is not the only goal of that program. The field of social hygiene includes sex problems in general, i.e., marriage, divorce, illegitimacy, prostitution, and sex education, in addition to its interest in syphilis, gonorrhea and the other lesser known venereal infections.

Just as the primary responsibility for diagnosis and treatment of these diseases rests on the medical profession, so must we count on law, religion, sociology, and general education to cope with the other sectors. Home, school and church, for example, are the primary sources for sex education; the police and courts are accountable for law enforcement against commercial prostitution. And the entire community is responsible for maintaining a civic environment conducive to happy, healthy growth and living for the whole population—particularly youth. Hence, aside from his specialized field, the physician can aid social hygiene progress by understanding and supporting sound principles and practices in sex education, law enforcement, and social protection.

Returning to the medical aspects of social hygiene, a bit of retrospect may not be amiss, as many younger physicians find almost unbelievable the conditions under which venereal disease treatment was conducted a few brief decades ago.

Forty years ago Washington's venereal dis-

ease sufferers, like those in the rest of the country, had to depend mainly on gold-brick proprietary panaceas or fakers, herb doctors, Indian healers and other charlatans for treatment. Most physicians didn't relish practicing in this field. It wasn't considered "respectable."

A noted professor in a leading medical school had written a book of advice to his colleagues in 1882. The volume carried the following admonition: "Gonorrheal and syphilitic cases are not especially desirable on any account except for the fees they bring; they are dirty secret cases and rather repel than attract their victims and their friends from the doctor who attends them, when they require a physician for other diseases. Attending them will, however, often enable you to pick up a handsome cash office fee. Take care that your reputation for attending venereal disease does not overshadow or eclipse other kinds and entail the social ostracism and loss of family practice that would follow..."

One of the country's noted urologists had that early medical attitude in mind when he said in 1927, "If the social hygiene movement has done nothing more, its success in making venereal disease treatment respectable would justify its existence."

But then, virtually the entire scientific regime for treating venereal infections is a product of the twentieth century. Specific diagnostic and treatment procedures appeared on the stage only with the arrival of Ehrlich, Wassermann, Schaudinn and their successors. And, even in

the intervening period, tremendous advances have been made. Contrast, for example, the first coarse salvarsan (which, as some physicians then said, was "more dangerous than the lues itself") with the refined arsenicals available today. Consider, too, the centuries of nonspecific treatment of Neisserian infections as compared with today's use of the sulfa derivatives and penicillin. Scientific medicine has a more adequate armamentarium now, and it is using the ammunition so effectively that venereal disease quackery no longer has this field to adventure in and exploit.

To take full advantage of these new therapeutic aids, however, there needs be a stepping up of case-finding and case-holding. In these processes the physician can help greatly by reporting his cases to the Health Department, not merely for statistical purposes, although valid statistics are important, but also to assure the follow-up of recalcitrant cases and the locating, when possible, of sources of infection.

In conclusion, here is a brief list of the more important local advances in social hygiene during the past decade:

1. A full-time venereal disease officer in the Health Department.
2. Provision of hospital beds for venereal disease sufferers.
3. More and better clinic facilities, including night clinics.
4. More policewomen.
5. More adequate budgets for venereal disease control.
6. Better law enforcement against prostitution.
7. More public education on social hygiene problems.
8. Better handling of school exclusions due to venereal infections.
9. Free drugs and free laboratory diagnosis for physicians.

HENRY H. HAZEN, M.D.

In and Out of Focus

BY THE OBSERVER

Our Most Dangerous Foe

The deadliest foe of medical societies is apathy. Those of us in official capacities need not be troubled too much by differences of opinion or a lack of unity within our organizations. More often than not it is a healthy symptom. But indifference is another matter and a serious one.

Too many doctors just aren't interested in controversial medical issues of the day. Sometimes one feels that they will become concerned only when the situation affects them directly. Then chances are they will condemn their leaders who have striven so unsuccessfully to arouse them from their lethargy. But it may be too late, changes having come to pass which were never thought possible.

Well, it need not turn out as badly as this. Many of us will at least try to prevent it. One of the most effective channels through which physicians are kept informed of developments are the state medical journals and county medical society bulletins. Many of them are expertly edited and widely read. An unusually well written editorial on the organization of medical care appeared in the November 30 issue of the *New England Journal of Medicine*. The *Journal* editorializes in part as follows:

"Basically, there are two problems with which both the public and the medical and allied professions are concerned: that of paying for medical care and that of assuring the highest quality of medical care for the most people. The first is purely an economic problem, and almost any solution is bound to benefit both the public, which bears the costs, and the physicians, nurses,

hospitals and other non-tax-supported groups that provide medical service, much of it on a partial or complete charity basis. The second problem has economic, political and technologic aspects. Its technologic phase is obviously the sole concern of the medical profession, which alone has the knowledge on which to base judgments of the quality of professional service or to institute improvements in the care of patients, in institutional standards or in the training of physicians. The public, however, has a direct concern in seeing to it that advances in medicine are made available as rapidly and as widely as possible. Here is the chief source of friction, since, in order to achieve the double objective of distributing the costs of medical care most equitably and of providing the best quality of medical service to the largest number of persons, governmental intervention at either the local or the federal level is contemplated. One group believes, with some justification, that the quality of medical service available to the country as a whole is inadequate compared with what it ought to be, both as regards hospital and laboratory facilities and the professional competence of those who utilize them. The other group contends, also with some justification, that facilities may not be ideal but are adequate in most portions of the United States, that these are being constantly improved by organized medicine and that any advantage gained temporarily in the improvement of professional standards made possible by a federal scheme would soon be lost in the inevitable political regimentation that would result.

"These are matters with which every physician should be concerned both as a citizen and as a doctor. The inertia of the bulk of the profession, combined with an opposition to change on the part of medical organizations, has led to a situation in which public opinion has forced the hand of the medical profession. Now the inevitability of some change is generally accepted. It is to be hoped that more local experimentation with different plans will be possible before a national health program is organized, so that the latter can be based on knowledge gained through experience. Those who wish to keep themselves informed on developments in this field should follow the reports published in the Organization Section' of the *Journal of the American Medical Association* and should read the British White 'Paper, the text of the Murray-Wagner-Dingell Bill and a report to be published that summarizes the ideas of those who have been particularly concerned with the development of a national health program. This is a field that should be approached with the same objectivity and detachment as a scientific experiment, so that the profession may make real contributions toward the solution of a problem with which both physicians and the general public are deeply concerned."

Mind Over Matter

Old age, always an unwelcome visitor, thrusts himself on us regardless of our wishes. Sometimes we make ourselves ridiculous in our striving to evade him. This has been demonstrated often in your Observer's relations with the medical profession. For physicians are not free from the desire to escape the ravages of time. They, like their patients in their advanced years, have illusions as to their physical prowess and youthful appearance. Often this reaching out for something which is forever lost is pathetic. In fairness it must be said that the majority take things as they come and adjust their lives to each stage of their existence.

Years alone, of course, are no criterion of age. Dr. William Seaman Bainbridge, speaking before the Second Annual Meeting of the American Geriatrics Society at New York, comments on this fact in the following fashion.

"How are we to define old age? What yardstick is the proper one to use? Are we to judge by the tick of the watch, the turn of the calendar, the condition of the arteries, the metabolic rate, the alertness of the mind, the physical prowess of an individual—or by his reaction to the early days of spring? There is the problem! We talk much of hygiene, sanitation, preventive medicine, vaccination, and proper diet; yet when men knew nothing of these things they lived years longer than we do today, despite our increased span of life."

"No one can arbitrarily set an age when man must lay down his work, kill his creative genius, throw his talents to the winds, and give himself up—to what? I hardly need to mention that a man may be old at 20 and young at 70. An active interest in daily events, a broad outlook, a sense of humor, a zest for living, all tend to keep a man young in spirit and in productivity, and often in physical well being, no matter how the years add up. The will to do is as great a factor today in keeping an individual a going concern as it has been since the earliest days. 'As a man thinketh in his heart so is he' is still an incontrovertible truth, and science has just caught up with it. Today we can measure the effect of the mind on the metabolism of an individual: when a thermometer is held tightly in each hand and the mind is strongly centered on one hand, the metabolic rate on that side, as expressed in mathematical terms of temperature, can be increased. The transference of

thought to the other hand causes the temperature to fall in the first hand and to rise on the side which is the new focus of thought."

By way of encouragement to oldsters, Dr. Bainbridge says:

"In this era of global warfare the older individual is becoming more and more important. Men of experience are increasingly in demand in industry, in finance, in government, and in planning for the postwar world. As the young men go off to war, the older men are given an opportunity to prove their mettle—and they are doing so most successfully in every conceivable field of endeavor. Lessened physical energy is often more than compensated for by the wisdom resulting from experience and long training.

"A number of years ago careful tests were made to find 'the physical and mental abilities of later maturity.' Various comparisons were made between groups of men 25 to 35 years of age and men from 65 to 78. Twenty-five per cent of the older group equalled or excelled in intellectual ability the average of the younger men, and a number past 70 years stood well above the rank and file of men in their thirties.

"Sir William Osler once said—and it seemed to those who took him seriously that he was agreeing with the advocates of the lethal chamber for men over 60—: 'Take the sum of human achievement in action, in art, in literature, subtract the work of the men above 40, and while we should miss great treasures, even priceless treasures, we would practically be where we are today . . . The effective vitalizing work of the world is done between the ages of 25 and 40.' But many years before Osler's day, the great historian Macaulay said: 'It is the law of our nature that the mind shall attain its full power by slow degrees, and this is especially true of the most vigorous minds . . . That all the most valuable books of history, of philology, of physical and metaphysical science, of divinity, of political economy, have been produced by men of mature years, will hardly be disputed.' Perhaps the truth lies between these two statements."



*You Can't
Read
Everything*

Like many others, your Observer reads only a fraction of the books and periodicals that come to his office and home. And in common with most people, he looks forward to a time when it will be possible for him to do all the reading he would like to do. Of course, this is only wishful

thinking for the leisure hoped for is 'more often than not never realized. As he well knows, the solution lies in not waiting until it is convenient to do so but to plan one's reading, concentrating on the literature one enjoys and finds of most value.

Dr. Charles B. Van Zant has something to say on this subject in the December, 1944 issue of the *Rocky Mountain Medical Journal*. Writing under the title, "Dehydrating Our Medical Reading," Dr. Van Zant offers his solution for busy physicians who want to keep up on their reading of scientific matter.

"With knowledge in increasing degree hurled at him from every side," Dr. Van Zant says, "the medical man of today stands appalled as he views the ever-retreating mirage of his hopes to compass his reading.

"Particularly with a large practice consuming nearly all his time and energies, it is impossible for him to read, digest, or assimilate the great mass of printed matter that comes before him in book form, magazine, or general reading. Of very necessity he must slight it in some degree, and run the risk of tobogganing toward mediocre attainment of his desires and needs. That conclusion is inevitable if no other way lies open to him.

"Sixty years of practice have not been without many lessons of value for the present writer. Among these, many years ago, came the conclusion that, if even moderately, one were to keep up with the advances of medicine, there was great need of some time-saving devices to accomplish that end.

"Especially is that aim necessary in medical teaching, where careful sifting of material, emphasis on real values, and conciseness of expression are so necessary to effectiveness . . ."

"Feeling his own need of some means to solve the difficulties . . . touched upon, the writer many years ago hit upon and put into effect a scheme that has been of much use to him personally. As a suggestion only, and with due modesty, it is offered, in case any of his colleagues might care to give it a trial.

"In brief it consists of two features—the use of note books and scrap books.

"First—The use of note books. Two or three will be needed, and they should be durable and well bound. One page or a part of it is sufficient for one subject, disease, or symptom complex—skeletonized and stripped of all padding. A second or third page is left blank for subsequent additions on the same subject. Each page

of the book is numbered and its subject indexed on the front sheets of the book.

"Naturally this material will come from standard textbooks. Its selection and condensing will be quite a labor, but once done, it will be valuable for quick reference for years ahead. In these note books a most useful feature is culled from *Pathological Physiology*—namely brief summaries of individual symptoms, or signs or syndromes such as dyspnea, cyanosis, heart murmurs, heart defects, pulse, respiration and temperature abnormalities, loss of weight, pigmentation, convulsions, reflexes, pupillary changes, exophthalmos, and scores of other alterations of function in disease.

"Secondly—The use of scrap books. Several of these, uniform in size and type, should be acquired for use in the years to come. In these scrap books are pasted clippings from one's reading, often illustrated. These clippings should be short, crisp, and selected for their future value. Thus a veritable mine of wealth is accumulated and preserved, much of it not contained in any textbook. Following the first page used, one or more pages are left blank for future clippings, the number of such blank pages reserved being in proportion to the importance or scope of the particular disease or subject involved. The scrap book pages are numbered and the contents indexed at the front. The clippings are cut from one's medical magazines when read, and are saved for insertion in the scrap book at any leisure hour.

"In contrast with wading through numerous textbooks to get a single desired fact, one will be surprised at the saving of time and great value of these scrap books."

"If the plan suggested, or any modification thereof, is faithfully persisted in, I believe that it will prove an almost continuing postgraduate course in its economy of time, ease of reference, and richness of scope."

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It May Be Legal But— Last month your Observer had something to say about the Association of American Physicians and Surgeons. He tried to make it clear that he had no quarrel with any group which honestly sought to improve the status of the medical profession but deplored the Association's negative attitude. Having delivered himself of his views, he had no intention of commenting further on the Association. However, an address by Mr. Rollen Waterson before the Wayne County Medical Society on December 5, 1944, has come to his attention.

In view of the statements made by Mr. Waterson, especially with reference to the Group Health case, he feels that he should add something to what he has already said.

Mr. Waterson, who is Executive Secretary of the Lake County Medical Society, Gary, Indiana, sponsors of the Association, told Detroit physicians that the first objective of the Association is "predicated upon the assumption that physicians lawfully may organize to refuse participation in schemes for the distribution of their services which they consider opposed to their best interests or to the interests of their patients." He referred to the indictment of the American Medical Association, the Medical Society of the District of Columbia and individual physicians, charging them with restraint of trade. He said there is no analogy between the actions of the two organizations convicted in this case and what the Association of American Physicians and Surgeons proposes. Competent legal counsel, he said, has advised the Association of its rights under the law.

This assurance has a familiar ring. Prior to the legal difficulties in which the A. M. A. and the Medical Society of the District of Columbia became involved, the ablest attorneys in the Nation's Capital assured the Society that it was within its legal rights in doing what it did. Despite this assurance, everyone knows the result.

Views expressed by the Society's legal counsel, to whom a copy of Mr. Waterson's talk was sent, are highly significant. He directed attention to Mr. Waterson's conclusions:

"First, that physicians may organize to refuse participation in schemes for the distribution of medical care such as the Group Health plan and plans organized under an Act of Congress or under the laws of any State.

"Second, having organized, physicians may refuse to associate professionally with those individuals or institutions that do participate in such schemes for rendering medical care.

"Third, it is the law that a voluntary association may discipline its members for violation of any reasonable rule it has adopted."

"These conclusions are reached," the counsel says, "on the theory that there is nothing in the decisions of the Court of Appeals or in the Supreme Court of the United States in the Group Health case that affects these rights. Frankly, I am forced to disagree with the conclusions reached.

"While the general conclusions of this article may be theoretically sound, it must be borne in mind that the gist of a violation of the Sherman Act involving either a combination or a conspiracy is essentially a matter of intent. In the Group Health case, I submit that the American Medical Association and the Medical Society did no more than the acts contended for in Mr. Waterson's article. Yet, while conceding each individual act performed by the defendants might be lawful, the Department of Justice took the position that those acts were performed for the unlawful purpose of hindering Group Health in its business, the Washington hospitals in their business, members of Group Health and the business of physicians. The American Medical Association and the Medical Society were found guilty as charged, on the theory that they did the acts complained of for the purpose of hindering others.

"Thus, to me it is plain that the line between what is legal and illegal in a Sherman Act case, being essentially a question of intent, is tenuous, and if an intent to restrain or hinder could be imputed to acts of the character described in Mr. Waterson's article, then it might very well be that a successful prosecution might be maintained under a State Anti-trust Act if the State law should follow the principles laid down in the Group Health case or under the Sherman Act if any of the restraints occur in areas covered by Section 3 of the Act.

"Certain other conclusions are contained in the article of Mr. Waterson with which I am not wholly in accord, but to discuss all of these differences would require a paper as long as that of Mr. Waterson, and it is my thought that you merely wanted my ultimate view of the conclusions reached by the article."

★

"I Am My Brother's Keeper" Nothing disturbs physicians more than the prospect of regimentation. With few exceptions, they predict dire consequences if it should occur. The truth is that this apprehension is only partially justified. As a matter of fact, we are already regimented to a considerable extent. But

the degree to which the medical profession will eventually be regimented will depend more than most physicians are ready to admit, upon themselves. There is nothing new about this statement. It has been said so many times that readers of this column are perhaps weary of its repetition, but nevertheless it is true.

Illustrative of the position taken by most doctors are the conclusions of Dr. James A. Ryan, President of the Southern Medical Association, in an address to his colleagues in November of last year. Dr. Ryan said:

"Considering the record of the achievements of the profession, as written on the pages of the history of American medicine, the question arises: Could or would all this progress made in caring for the ills of human kind have been possible if the profession had been regimented and regulated by a political bureaucratic control?

"Results in the event of such legislation in the remote future will be characterized by, first, a large proportion of the older and more influential physicians retiring from active practice; and, second, the practice of others will be found running along the path of least resistance. Many of them will render a minimum of service, thus taking out much and investing little. Such legislation will clearly vitiate the traditional mutuality of obligation between the medical profession and the public.

"Physicians are socially-minded people. If the fundamental principle of socialism is the division of all the wealth and all the treasure and all the property between the have and the have-nots, then the physician is a socialist. He has always divided his time and his knowledge and his skill and his energy between those who have and those who have not the wherewith to pay for his services. He does not have to be regimented to do it. He does it willingly and cheerfully.

"It is probable that this world is entering a new era, when peace and good will and understanding will not be empty words—an era when prophylactic measures for the cure of the ills of the body politic will be instituted and enforced just as successfully as has been done in the prevention of disease and suffering in the human body.

"All the peoples of the world today are neighbors. They are even more, they are brothers. And, they are learning the answer to that age-old query: 'Am I My Brother's Keeper?' The medical profession has always known the answer, and that answer is: 'I Am My Brother's Keeper.'"

Your Observer is most sympathetic to Dr.

Ryan's point of view. However, his reasoning can hardly be called logical. Of course, we do not want to be regimented by the Government and it need not happen. However, we must realize that we are entering an era when new methods are called for. We just cannot pick up our things and refuse to play in a changing world. If we are indeed our brother's keeper, we will recognize this fact by constructive action. If regimentation of the medical profession is necessary to a greater degree than at present, we can do that job ourselves.



"The attitude of the people of the United States is favorable to insurance in all its true forms." So states the *Journal of the Tennessee State Medical Association* for December, 1944. "It is probably true that more insurance is in force in the United States than in any other country in the world," the *Journal* continues.

"The attitude of the public is so favorable to insurance that there may be danger of a favorable reaction on the part of the public to legislative proposals often referred to as insurance, but which in reality are not insurance at all.

"Insurance, as we know it, implies a contractual relationship between an insured person or group and an insurer. The insurance contract specifies the amount to be paid by the insured to the insurer in the form of a premium, and the benefits that are to accrue to the insured or his beneficiaries. The circumstances under which the benefits become due are also stipulated. If a dispute arises between the insured and the insurer as to whether or not a benefit is due, the matter may be referred to a court of justice for adjudication.

"The insurer exercises no control over the insured as to how he uses the benefits paid to him. He is free to use them as he may choose."

"The proposition, then, that the federal government tax wage earners and employers a certain sum in proportion to wages received and paid, and use such tax money to support a system of medical care, cannot be classed as insurance by any sort of reasoning. Especially is this true when it is pointed out that the premium payer, or in this instance, the taxpayer, receives no contract which stipulates the benefits to be received. The in-

sured in this case would be paying in cash for benefits, the nature of which would be determined entirely by an agency of the federal government.

"It should be pointed out also that the insured in this case is not free to spend his benefit in a manner which suits him, but on the contrary is compelled to accept the direction of an administrative agency empowered to make regulations concerning these benefits and to alter them from time to time, to say nothing of the power of the Congress to alter any commitment of an agency of the federal government at any time.

"Such a proposition is nothing more nor less than a communistic scheme—it is not insurance as we know it. To knowingly apply the term insurance to such a scheme is nothing more nor less than rank deception."

It seems to us that our good friend, the Editor, whether he knows it or not, is out on the proverbial limb. In the first place, his argument that a Federal system of medical and hospitalization benefits such as is proposed under the Wagner-Murray-Dingell bill is not insurance because no written contract would be issued the insured, would hardly hold water. Benefits would be specified even though they were not embodied in the formal contract and certainly it would be true that if disputes arose, there would be provision for adjudication.

As for the insurer exercising control over the benefits to which the insured is entitled, it appears that the Editor is thinking in terms of cash benefits or indemnity insurance. He should not forget that the American Medical Association has approved both indemnity and medical service plans. Under the latter, the "insurer," which may be a medical society, determines the benefits which accrue to the insured or subscriber. And certainly the beneficiaries under such schemes must accept the decision of the administrative body as regards benefits to which they are entitled. So, if a Government system such as is outlined is communistic, so are medical service plans.

Now, it may appear that your Observer favors a compulsory sickness insurance scheme under the Government's auspices. On the contrary, he believes in voluntary rather than compulsory methods. Certainly privately sponsored medi-

cal plans should be given a thorough trial before they are rejected.

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Nation's Youth Growing in Stature It has been a generally accepted fact that the youth of this generation are physically superior to their parents. This is now substantiated by the Metropolitan Life Insurance Company which reports its findings in its *Statistical Bulletin* for November, 1944. The *Bulletin* states:

"Stature shows distinct signs of increase in the present generation. The average height of men in the ages 20 to 29 examined at induction stations for the armed service in May 1943 was 68.15 inches (without shoes). This figure is about two thirds of an inch more than the average of 67.49 inches for the first million draftees of ages 21 to 30 examined at mobilization camps in the last World War, in 1917. The figure cited for 1943 is based upon an analysis of data recently published by the Office of the Surgeon General of the Army, and is adjusted to allow for the omission of cases inducted into the Navy, for which figures are not available.

"Not only has the average height increased over this period, but as one would naturally expect, the proportion of tall men among the 1943 selectees was also greater than among those of the last war. In the age group 20 to 30 years, the proportion of men 5 feet 10 inches or over among the recent selectees was 27.5 per cent, as against 22.4 per cent reported for the men in 1917. The proportions of sixfooters were 8.8 and 6.5 per cent respectively. In other words, the proportion of sixfooters among young men is about one third greater at present than it was a quarter of a century ago."

Another aspect of the physical development of American youth is the growth in stature of school children:

For example, comparative series of observations among elementary school children in Toronto show that the typical elementary school boy or girl of six in 1939 was actually two inches taller than the child of the same age in 1892. At 9 years of age this difference was about three inches, and at fourteen about 3½ inches for boys, and a little over two inches for girls. Thus the typical six-year-old child in 1939 was actually a shade taller

than the typical seven-year-old in 1892, and the typical thirteen-year-old in 1939 was about an inch taller than the typical fourteen-year-old in 1892. In part, these differences may represent accelerated growth and early approach to full stature, the ultimate difference, in adult life, being somewhat less than that found at the rapidly growing ages."

The *Bulletin* draws the following conclusions:

"There can be no question but that these very favorable findings with regard to increase in stature reflect the improvement in general health and nutritional conditions over recent decades. The alarm which has been voiced by some over the high rejection rates in our Army, quite overlooks the fact that standards of rejection are to some extent arbitrary and subject to adjustment according to conditions and the judgment of those directing the formation of the armed forces. What is more important, standards far above those required for the ordinary pursuits of life must be maintained. It is hardly too much to say that every prospective soldier in the front lines must be something of a potential athlete to be able to cope with the excessively heavy duties, wholly outside the scope of ordinary civilian activities.

"Thus there is every indication that the seemingly high rejection rates are in no sense due to a relatively low level of physique among our young people, but that any seemingly adverse comparison between the situation at the first World War and in the present conflict is due mainly to a difference in standards. While we still have far to go before optimal conditions for growth and health in childhood are established, unquestionably the trend has been favorable. With continuing advances in our knowledge of nutrition, coming generations of Americans should show gains in physical status beyond that attained by young adults of today."

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A Believer in Insurance

Views expressed in recent months by Dr. Morris Fishbein, Editor of the *Journal of the American Medical Association*, lead one to conclude that his outlook on the medical scene is changing and this Observer thinks for the better. Dr. Fishbein may not agree with this observation; nevertheless, his recent utterances are encouraging to those who have looked upon him as a symbol of standpattism. Perhaps, for reasons best known to himself, he is less hesitant about saying what he really thinks.

Last September, however, when Dr. Fishbein addressed the annual meeting of the State Medical Society of Wisconsin on postwar planning for medical service, he made it clear that he is still right of center. In the course of his address he said:

"I have said to . . . state medical societies in the United States from time to time that there is probably no one who believes more in insurance than I do. In Chicago you have to believe in insurance! I am insured in Chicago against almost anything that can happen in Chicago—and anything CAN happen in Chicago! I carry burglary, hold-up, fire, soot, smoke, water insurance. In Chicago you don't just carry fire insurance—you carry fire, soot, smoke and water insurance. We are also insured against tornado and flood, against automobile accidents that happen to you and by you, and almost anything else that you can imagine. I am a firm believer in the principle of insurance. I would say that on the whole I have benefited by insurance. I am a firm believer in the idea of insurance against the hazards of sickness.

"I am a firm believer in insurance against the costs of hospitalization. I am not, however, a believer in the idea that insurance is necessarily a function of the United States government. We here in the United States, under the system of private insurance, have become the best insured nation in the world from the point of view of so-called life insurance or burial insurance, depending on your point of view. We are the best insured nation in the world. There is no other nation in the world that has voluntarily so protected itself as have the people of the United States.

"Gradually there is coming to be more and more extension of the so-called insurance principle from the private point of view to meet the hazards of sickness and of hospitalization."

Well, no one can doubt that Dr. Fishbein favors sickness insurance providing it is underwritten by private insurance companies.

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Few members have served *Well Done!* the Society more loyally than Dr. Charles B. Campbell who, since 1929, has been the Society's Delegate to the Federation of Citizens' Associations of the District of Columbia. Because of ill health,

Dr. Campbell is now forced to resign.* In doing so, he submitted a highly interesting report to the Executive Board on November 27.

During the past sixteen years, many proposals made by Dr. Campbell, with the approval of the Society, have either become law or regulation in the District of Columbia. Among them are procedures to be followed in preventing blindness in the newborn, annual medical examinations of barbers and beauticians, and restaurant inspections to determine compliance with sanitary requirements. Successful efforts were also put forth to obtain new buildings for Gallinger Hospital and to retain the present Coroner's office. Opposed were the transfer of municipal hospitals from the Health Department to the Board of Public Welfare and rebuilding of the abattoir at Benning, D. C. Dr. Campbell deserves credit for his part in the realization of all these undertakings.

The Board expressed its deep appreciation and assured Dr. Campbell that the Society's membership is grateful for his services.

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If we of organized medicine **MEDICAL CARE** are honest with ourselves, we *Suspends* will admit that we have often *Publication* been intolerant of "outsiders' " views. This has been particularly true where the provision of medical care is concerned. The lofty manner in which some of our officials have dismissed the opinions of capable, serious men or women outside our ranks will plague the medical profession for many years to come. For the truth is that some of the changes in medicine for which they have fought have not only been accepted but are now a reality.

Within the past month, the Committee on Research in Medical Economics of New York announced the suspension of its publication *Medical Care*. This periodical was started in

(Continued on page 102)

* This was written a few weeks before Dr. Campbell's death on February 5, 1945.

War Section

SERVICE PHYSICIANS UNDER G.I. BILL*

Dr. Frederick A. Collier, Dr. Walter Palmer and Father Alphonse M. Schwitalla, the members of the Subcommittee on Postwar Education of Physician Veterans, were accorded interviews with officials of the Veterans Administration on the afternoon of October 16.

The Subcommittee called first on Dr. Charles M. Griffith in the office of the Medical Director, Veterans Administration Building, and after an exchange of courtesies was escorted by him to the office of Mr. Harold V. Stirling, Director, Vocational Rehabilitation and Education Service. Dr. Griffith explained that Mr. Stirling was in charge of the administration of title II of education of veterans of Public Law 346, 78th Congress, known as the "Servicemen's Readjustment Act of 1944" (the G.I. bill), and Public Law 16 was Mr. Stirling's responsibility.

Dr. Griffith explained that after the Committee's interview with Mr. Stirling to learn from him the present status of Public Law 346 and its application to the physician veterans, he would discuss with the Committee further the content and administration of the educational program itself which the Veterans Administration has projected or intends to project for the returning physicians.

I. ELIGIBILITY OF INSTITUTIONS

Mr. Stirling suggested that the committee discuss first the eligibility of institutions for recognition as educational centers in which veteran physicians might receive such educational benefits as are provided for under the law. He turned to section 400, part VIII, paragraph 4, and called attention to the fact that it is incumbent upon the administrator to

secure from the appropriate agency of each state a list of the educational and training institutions (including industrial

establishments), within such jurisdiction, which are qualified and equipped to furnish education or training (including apprenticeship and refresher or retraining), which institutions, together with such additional ones as may be recognized and approved by the administrator, shall be deemed qualified and approved to furnish education or training to such persons as shall enroll under this part.

Mr. Stirling noted that the law distinguishes between institutions (giving training) "and establishments furnishing apprentice training on the job" (see paragraph 5). The institutions in which discharged physicians would receive their postdemobilization education, such as the hospitals, will, of course, qualify as institutions and will not be considered merely as "establishments furnishing apprentice training on the job."

To qualify as "institutions," the schools of medicine and the hospitals in which the returning physician will be further educated, will have to appear by name on a list of educational and training institutions furnished by the appropriate agency of each state to the administrator. The administrator is given authority by the law to "recognize and approve" institutions on his own initiative. Obviously, however, the administrator will not undertake as a rule an approving or accrediting program and will rely on such lists as are furnished him by the appropriate agency of each state.

As far as medical education is concerned, there is very little difficulty about the schools of medicine,† since most, if not all, of the states would readily submit the names of schools recognized by the Council on Medical Education and Hospitals of the American Medical Association. Much greater difficulty, however, will be found in supplying to the administrator a list of the recognized and approved hospitals, and a decision will have to be made concerning the list

* Reprinted, with modifications, from *The Journal of the American Medical Association*, 1944, 126, 709.

† The problem of the state approved but not nationally approved schools of medicine was not touched on in this conference.

which all will agree will be the proper list to submit to the administrator. Mr. Stirling is of the opinion that it might be well if the administrator's office send to the governors of the various states such lists of institutions, schools and hospitals as are recognized and approved by appropriate agencies with the request to the governor to indicate his approval or disapproval of these lists as appropriate educational centers for the further education of the physician veterans under the program. Naturally, there are other outstanding problems concerning the eligibility of institutions which will need further discussion.

The important conclusion, however, is that in Mr. Stirling's opinion the schools and hospitals can be regarded as institutions within the intent and scope of the Servicemen's Readjustment Act of 1944, provided such institutions qualify under the provisions of paragraph 4, part VIII, title II, Public Law 346.

II. ELIGIBILITY OF INDIVIDUALS

"Any person who served in the active military or naval service on or after Sept. 16, 1940 and prior to the termination of the present war and who shall have been discharged . . . and whose education or training was impeded, delayed, interrupted or interfered with by reason of his entrance into the service . . . and who either shall have served ninety days or more . . . shall be eligible for and entitled to receive education or training under this part" (section 400, part VIII, paragraph 1). A number of provisions and limitations are included in the unquoted section of this paragraph but, in general, the substance of the provision is accurately given. Discharged servicemen under 25 years of age at the time they entered the service are assumed to have had their education impeded or delayed, while those 25 years of age or over at the time they entered the service will be expected to supply evidence that such a delay or obstacle to their education occurred.

With reference to the section just quoted, Mr. Stirling was of the opinion that any physician who is now in any of the branches of the service and has been on active duty for more than ninety days will be eligible for any of the benefits provided by the law. Even those who are more than 25 years old and desire refresher or other courses will no doubt

be considered eligible even though they may have entered the Army at a time when their education might have been assumed as completed, since the law in providing refresher and retraining courses is naturally to be interpreted in a liberal spirit.

Any person who has been in active service for three months will be entitled to a period of one year of education or for such lesser time "as may be required for the course of instruction chosen by him." Those servicemen who have been in the service for more than the minimum period of three months may receive additional periods of education or training, the period "not to exceed the time such person was in active service on or after Sept. 16, 1940 and before the termination of the war." Periods during which a serviceman was receiving his education under the auspices of the Army or Navy while on active duty cannot be counted toward time credit for a prolongation of the educational period. The committee asked Mr. Stirling to apply this to the ordinary clinical residency. It was explained to him that the residencies in our hospitals, for example, were one, two or three years or more in length. He replied that:

Those in service three months are entitled to one year further education;

Those in service twelve months are entitled to two years further education;

Those in service twenty-four months are entitled to three years further education.

Intermediate periods of service entitle the serviceman to intermediately long periods of education; thus if a serviceman has served six months he is entitled to eighteen months of further education.

III. TUITION AND FEE BENEFITS

The law provides that the administrator shall pay to the educational or training institution the tuition costs and fees as are customarily charged and may also pay for books, supplies and equipment and other necessary expenses, provided the payments with respect to any one person should not exceed \$500 for an ordinary school year. These payments are not to be paid to "establishments furnishing apprentice training on the job." The law provides that if the institution has no established tuition fee or if the administrator deems the established tuition fee to be

inadequate compensation, the administrator is authorized to provide for the payment. Again, however, with the \$500 ordinary school year limitation.

Applying these provisions of the law to the case of residencies in our hospitals and courses in our universities for our physician veterans, Mr. Stirling was of the opinion that there would be no difficulty about the payment of tuition and fees by the administrator for those physician veterans who elect courses in schools of medicine or for those who elect clinical courses in university hospitals where a formal program has been inaugurated. He was also of the opinion however that, provided the hospital can be certified to the administrator by the appropriate state agency as a competent educational and training institution, the administrator may fix the tuition to be paid to such an institution under the provisions of the law (see last sentence, section 400, title VIII, paragraph 5).

The arrangements heretofore in use in hospitals were explained to Mr. Stirling, it being pointed out that the hospital, generally speaking, not only did not charge tuition but actually offered the resident a stipend. He replied by saying that in his opinion if the hospital is certified as a bona fide educational institution the tuition for the physician veterans can be paid to that hospital even though the hospital still continues to pay a stipend to the veteran.

IV. SUBSISTENCE BENEFITS

The law provides further that on application to the administrator the person taking courses shall be paid a subsistence allowance of \$50 per month if without a dependent or dependents or \$75 per month if he has a dependent or dependents.

This provision again, Mr. Stirling believes, is applicable to the physician veterans who choose to take courses in medical schools or hospitals. Mr. Stirling is of the opinion, furthermore, that the subsistence benefit may be paid the physician veteran even if he receives a stipend from the hospital, since in some cases the physician veteran will undoubtedly live outside the hospital and in many cases there will be a noticeable disproportion between the stipend paid by the hospitals and the salary level of the physician veteran before his discharge. It was pointed out, furthermore, that the subsistence benefit includes "regular holidays and leave not exceeding thirty days in a calendar year." There may still be some question whether the provisions of the law pertaining to attendance in courses on a part time basis and a corresponding part compensation for productive labor are applicable here but there seems no reason to anticipate an adverse ruling on this point. Furthermore, it should be noted that the administration has thus far defined a school year as thirty weeks for the purpose of administering the law; hence the tuition allowance of \$500 maximum can be made payable to the institution every thirty weeks if that is the interpretation and regulation under which the educational institution is operating. The subsistence benefit is not affected by the length of the school year.

SUBCOMMITTEE OF THE COMMITTEE ON POSTWAR MEDICAL SERVICE OF THE AMERICAN MEDICAL ASSOCIATION

Frederick A. Coller, M.D., *Chairman*

Walter Palmer, M.D.

Alphonse M. Schwitalla, S.J., *Secretary*

THE CRITICAL NURSE SHORTAGE

"Our battle casualties are mounting daily," Major General Norman T. Kirk, The Surgeon General, stated at Mayor La Guardia's Nurse Recruiting Meeting in New York City, on January 4. "Not only has this increased the nursing problem overseas," he continued, "but it increases the problem of taking care of those casualties who are being returned from overseas.

"Last month over thirty thousand wounded and sick were returned to the United States by airplane and hospital ship.

We expect that this number will be even greater this month. These men all need nursing care. We had foreseen this emergency. Since last October the Army Medical Department has been stressing the need for 10,000 additional nurses. We sent a personal appeal to each one of the 27,000 nurses that the War Manpower Commission told us were available for duty. Our returns from that appeal were pitiful. We received 760 answers and signed up 227 nurses from that group.

"This same shortage of nurses is evident in the Zone of the Interior. On January 2 Percy Jones General Hospital had 3,699 hospital and convalescent patients. There were 85 army nurses there to take care of them. That is a ratio of 1 nurse

to 43 patients. In addition to the army nurses there were 33 civilian nurses, 23 nurse's aides and 36 WAC technicians. Including the civilian nurses, and nurse's aides, the ratio is still 1 to 26.

"The situation has grown so critical that suggestions have been made that the Army draft nurses through Congressional action. It looks as if this will be necessary to meet the immediate demand for nurses."

Forty-eight hours later, in his message to Congress, President Roosevelt said, "Since volunteering has not produced the number of nurses required, I urge that the Selective Service Act be amended to provide for the induction of nurses into the armed forces. The need is too pressing to await the outcome of further efforts at recruiting."

In the District of Columbia, a joint meeting was

held by the Procurement and Assignment Service for Physicians and the District of Columbia Committee on Nursing. Methods by which volunteers for the Army Nursing Corps could be obtained in the District were discussed at length. It was agreed that the critical need for nurses in the Army should be widely publicized not only through the press but over the radio. Furthermore, both Committees decided it was most important that there be an orderly withdrawal of registered nurses from the Nation's Capital; that those who were most essential to maintenance of civilian health be not made available; and that the essentiality of the latter group be impressed upon those who comprise it, especially nurses holding key positions in hospitals, nursing schools and other medical institutions.

COMMANDER FULCHER FIGURES IN NAVY INCIDENT

Washington physicians will find the following release issued to the press by the Navy Department on December 7, 1944, of considerable interest for it involves one of their colleagues.

"South Pacific Headquarters,—(Delayed)—A Navy brain specialist, flown to a remote South Pacific Naval base, performed an operation on a native recently which probably saved the native's life.

"The story commences with an accident in which Kalamalau, the native in question, was injured. He was taken to a Navy dispensary and found to be badly hurt.

"Eight ribs were fractured; a vertebrae was fractured, and—most seriously of all—his skull was fractured in two places. A thorough examination disclosed that the specialized skill of a brain surgeon was needed.

"A dispatch from the Naval Base at Efate in the New Hebrides, where the mishap occurred, to South Pacific Headquarters, started things moving. Captain Frederick R. Hook, Medical Corps, U.S.N., Area and Force Medical Officer, issued immediate orders for a neurological surgeon to prepare for the trip to Efate.

"Vice Admiral J. H. Newton, U.S.N., Commander South Pacific Area and Force, ordered his personal plane readied for the flight. An hour after the message was received, Commander Oscar Hugh Fulcher, Medical Corps, U.S. Naval Reserve, whose home is in Washington, D. C., was winging his way to Efate.

"There he consulted with doctors at the Naval Base dispensary. A thorough examination of Kalamalau was made. It was discovered that he had developed a blood clot on the right side of the skull with resulting pressure upon the brain.

"The following morning, Commander Fulcher, a peacetime member of the Georgetown University Hospital Staff, performed an operation to relieve the pressure. Kalamalau, who had been in a semi-comatose condition, became conscious. He smiled and spoke. Despite his other injuries he thanked the doctors smilingly and asked for food. Happily, he consumed a banana.

"Kalamalau is a native of the tiny islet of Mele, which lies across a narrow channel from Efate. Employed by the U. S. Navy, he is one of an unusual community which lives on Mele. Kalamalau's uncle is a native Presbyterian minister and the natives are unusual in that everyone on the islet is a member of the Presbyterian Church.

"Presbyterian missionaries from New Zealand have worked for years among the natives of Efate, and as a result many are devout church members. Kalamalau's uncle conducted prayer services before the operation was performed by Commander Fulcher and gave thanks in the presence of Kalamalau and other relatives after the successful operation had been completed.

"But Kalamalau is not unusual in that he works for the United States. Thousands of natives in the South Pacific Islands have been faithful workers at Navy, Army and Marine Corps installations throughout the time that the Americans have been fighting the Pacific war."

NEWS OF OUR MEMBERS IN SERVICE

Colonel John Minor, who for nearly two years has been Chief of the Medical Service, Woodrow Wilson

General Hospital, Staunton, Va., has been appointed Consultant in Medicine of the Third Service Com-

mand, which includes the states of Pennsylvania, Virginia and Maryland, with headquarters in Baltimore, Md.

Major Russell McNitt is now in charge of obstetrics and gynecology at West Point, New York.

Lt. Colonel Edmund Horgan, of the U. S. Medical

Corps at Foster General Hospital, Jackson, Miss., has been promoted to the rank of Colonel and will assume direction of the Hospital's surgical service.

Lt. Colonel Alva D. Daughton was interviewed in Paris by Fulton Lewis, Jr., February 5, during the latter's regular broadcast over the Mutual Broadcasting System.

LETTERS FROM PHYSICIANS IN THE ARMED SERVICES

From Captain Peter P. Brue, c/o Postmaster, New York, N. Y.:

My dear Mr. Wiprud: You no doubt are surprised to hear from me, but I am looking forward to the time I can be back in Washington and resume where I left off. Each day that goes by brings me that much closer. I hope it is not too far distant.

I just received your letter of Nov. 4. It seems your letters have been chasing me through France and then back to England. The above address is my correct one. Let's hope I don't have to wait too long for your next letter and the *Medical Annals*, which I haven't seen for more than six months.

As you can see I am in England. At the moment I am in charge of medical processing for all hospital returnees to duty. It is interesting to see the wounded returning to duty, but it is no easy task.

From Lt. Colonel Luther H. Snyder, c/o Postmaster, New Orleans, La.:

Dear Ted: Have very greatly appreciated the letters you have been writing to those in the service. Even when stationed not far from Washington it is amazing how out of touch with the profession on the home front one becomes. Your letters serve to keep us informed of the important medical events and trends in D. C., and also bring us the intimate bits of news and stories which help in reducing the feeling of distance from home.

From Lt. Colonel Edward J. Grass, c/o Postmaster, San Francisco, Cal.:

Dear Ted: Long time I no write, but you know how this man's army is, it's not stationary all the time. Sure enjoyed your last letter, and instead of reading all those books, you should be writing one. Here's a good name for one—"Mavourneen."

You know I have been having trouble with this wrist watch of mine. It's water proof, dust proof and no one has worn it but myself. Finally I unscrewed the back, and found a bug about $\frac{1}{4}$ inch long, wedged in between the wheels. Well, I was trying to figure out how that bug got in the works, and finally came to the conclusion that the bug crawled in between the ticks.

Last evening I got a close look at a wallaby. This is a kind of kangaroo, the small type, with a pouch located in the ab-

dominal region, for the carrying of their offspring. The mother wallaby took an apple out of a box nearby, and then, to my great surprise, one of the little wallabies crawled over to the box, grabbed an apple and jumped back into the pouch.

Keep 'em rolling, Ted, and if you have one more job wished on you, your wife is liable to raise Cain. I am feeling fine, and ready for anything that comes along my path toward Tokyo.

From Major William J. Tobin, Cushing General Hospital, Framingham, Mass.:

My dear Mr. Wiprud: Every now and then I feel that I should write you a few lines to let you know that all is well with me, although the amount of work is ever increasing.

I might mention in passing that I have been promoted to the rank of Major, and am now proudly wearing the gold leaves.

I think it is grand that the Medical Society has continued to send us the *Annals* regularly, and that you, personally, send us your "News Letters." By means of these communications, we who are in the service can keep in touch with what is going on in Washington. I am sure that I express the feelings of all of the members of the Society who are in the service that we are all looking forward to the time when we can return to Washington.

I guess Washington is a changed place since I left. I have heard it described as a "madhouse," etc., and no doubt many of the reports are true. Perhaps by the time that we who are in the service find it possible to return much of the mad scramble will have quieted down. No doubt it will.

From Lt. Colonel Alfred E. Brigulio, c/o Postmaster, New York, N. Y.:

Dear Ted: Your most recent letter just reached me after a rather circuitous route. As always, the news contained therein served to bring my thoughts back home; and I need not repeat how much your letters are welcomed. In order to avoid any future delays in the delivery of more of your mail our address is as shown above. I'll keep you notified if another change of address should occur.

We moved from our last post some time ago to cross the pond in a rather uneventful and dull crossing. A little rough on the first couple days but this rapidly settled to a relative calm. Our stay in the British Isles has resolved itself mainly

to one of acclimation. It is wet and cold with a predominance of mud. However the unit rapidly adjusted to the situation, and is now marking time.

There is little to be said at this time particularly in view of the rigid censorship regulations. Have visited some of the nearby towns of interest and have found the people here friendly and helpful. There are many points of historical significance but I have not had the time to see them. Hope to be able to tell you more about that later.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the business session, January 10, 1945:

Active Members

Joseph Edward Brackley, Captain, M.C., A.U.S., c/o Postmaster, San Francisco, Cal.
 George Daniel Denton, 3125 Cathedral Ave., N.W.
 Louis Moritz Eble, 1830 Eye Street, N.W.
 James Joseph Feffer, 1711 Rhode Island Ave., N.W.
 Harold R. Feinstein, Captain, M.C., A.U.S., 3130 Wisconsin Ave., N.W.
 Herbert A. Goldberg, Major, M.C., A.U.S., 2517—39th Street, N.W.
 Elizabeth W. Bailie Goldsworthy, 500 Ethan Allen Ave., Takoma Park, Md.
 Clark Paul Halstead, 1418 M Street, N.W.
 Josiah B. Henneberger, 1915 Calvert Street, N.W.
 Harold Lester Hirsh, 204—21 Street, N.E.
 James Raymond Hurley, PA Surgeon (R), U.S.P.H.S., Medical Center, Springfield, Mo.
 Ludwig George Lederer, 104 North Granada Street, Arlington, Va.
 Donald W. Mitchell, 900—17th Street, N.W.
 Frank S. Pellegrini, Captain, M.C., A.U.S., Vichy Army Air Field, Vichy, Mo.
 Roger Stanley Williams, 35 New York Ave., N.W.

Associate Members

Harvey H. Ammerman, 2944 2nd Street, S.E.
 Ella R. Fales, 1914 Grace Church Road, Silver Spring, Md.
 Irvin Morris Grassgreen, 4607—25th Street, Mt. Rainier, Md.
 Rowland Stanton Philips, Glenn Dale, Md.

The following applicants for membership will be voted on at the business session, February 14, 1945:

For Active Membership

Caroline F. Burpeau, George Washington University—1943
 Harry Albert Giltner, Kentucky School of Medicine—1898
 Joseph Patrick Kenrick, Georgetown University—1941
 Stephen Alexander McCarthy, Georgetown University—1931
 Maurice Mensh, George Washington University—1939

For Associate Membership

Donald Henry Glew, D.D.S., Georgetown University—1922
 Olive Pippy, Woman's Medical College of Pennsylvania—1911

The following applicants for membership will be voted on at the business meeting, March 7, 1945:

For Active Membership

Beatrice Bishop Berle, New York University—1938
 Edward Charles Durkin, University of Pennsylvania—1936
 Charles William Ordman, Johns Hopkins University—1939

For Associate Membership

Milton Irwin Roemer, New York University—1940
 Guy R. Stoddard, George Washington University—1939

Recent changes in membership status:

Active to Associate

Charles P. Cake
 John A. White

Resigned Active Members

Morris H. Levine
 William C. Sparks

Nine New Life Members

Chapter II, Article IV, of the Constitution of the Society, reads as follows:

Life members shall be active members who have been active members for a total of forty years. They shall have all of the privileges of active membership and shall be exempt from paying dues and assessments.

Our honor roll now numbers 70. The congratulations of the Society are extended to:

<i>Seniority Number</i>	<i>Date of Membership</i>
337 Charles M. Beall	April 6, 1904
339 Thomas J. Rossiter	April 11, 1904
340 James C. Wynkoop	April 21, 1904
345 James G. McKay	May 4, 1904
346 James F. Mitchell	May 4, 1904
349 Harry H. Donnally	May 6, 1904
353 Anna Bartsch-Dunne	October 5, 1904
354 Harry A. Fowler	October 5, 1904
356 E. Hiram Reede	October 5, 1904

who have for forty years been on the roster, meeting all dues and assessments and lending their support to the Society by frequent attendance. Their status is now elevated to Life Membership.

On The Home Front

In conformity with the new regulations of the Office of Defense Transportation, the following medical meetings of national importance have been cancelled: conferences of the American College of Radiology, February 9 and 10, Chicago; 19th Annual Meeting of the National Conference on Medical Service, February 11, Chicago; 41st Annual Congress on Medical Education and Licensure, February 12 and 13, Chicago; Annual Congress on Industrial Health, February 13-15, Chicago; National Tuberculosis Association, June 13-15, Buffalo, New York; 95th Annual Session of the American Medical Association, June 18-22, Philadelphia.

The Section on Neurology and Psychiatry met in the Society's Library, February 1. The following program was presented: "Neurological Changes in Polycythemia," Drs. Antonio Gonzalez-Revilla and Walter Freeman; "Psychoses in Naval Inductees," Lt. Otto A. Will, Jr., M.C., U.S.N.

The Section on Pediatrics was addressed by Mr. Stanley J. Tracy, Assistant Director, Federal Bureau of Investigation, at its regular meeting, January 25. His subject was "Footprinting of Infants."

The George Washington University Medical Society held its third meeting, January 20. Dr. Elmer V. McCollum, Professor of Bio-chemistry, School of Hygiene and Public Health, Johns Hopkins University, spoke on "The Use and Abuse of Vitamins." Discussion was opened by Drs. William Earl Clark and Joseph H. Roe.

At the October meeting of the International College of Surgeons, Drs. Edgar Davis, O. A. Engh, and Emil J. B. Hildenbrand were elected Fellows. Dr. Garnet Ault was elected to membership in the College.

The Clinico-Pathological Society met January 2 at the home of Dr. William H. Jenkins. Lt. Colonel Alfred R. Shands, Surgical Branch, Office of the

CALENDAR OF MEETINGS

January 3	Committee on Medical Care
January 4	Section on Neurology and Psychiatry
January 10	Scientific Meeting of Society
January 12	Procurement and Assignment Committee
January 17	Joint meeting of D. C. Committee on Nursing and Procurement and Assignment Committees for Physicians and Nurses
January 17	Section on Pathology
January 19	Grievance Committee
January 22	Committee on Postgraduate Education
January 24	Scientific Meeting of Society
January 25	Section on Pediatrics
January 29	Medical Bureau Committee
January 29	Executive Board
January 31	Committee on Service Physicians

Air Surgeon, spoke on "Convalescent Rehabilitation in the Air Corps." Dr. William H. Hough discussed "Post-arsphenamine Jaundice."

The Washington Ophthalmological Society met January 8. Dr. Ralph I. Lloyd of Brooklyn, New York, spoke on "Proptosis." "Extraction of Magnetic and Non-magnetic Foreign Bodies" was the title of a motion picture presented by Dr. Arno E. Town. Case presentations were made by Drs. Sterling Bockoven, Ronald A. Cox, Paul Levatin, Roy A. Stewart and Richard Wilkinson.

The National Committee on Alcohol Hygiene, Inc., with national headquarters at 2030 Park Avenue, Baltimore, held its first institute on alcoholism, September 14. Dr. Robert V. Seliger, Medical Director of the Farm for Alcoholic Patients and Executive Director of the Committee, was one of the speakers. The National Committee is cooperating with other groups in the country who feel that alcoholism is a problem which needs to be met by vigor-

ous nation-wide, concerted scientific prophylaxis and diagnostic treatment facilities.

The Washington-Baltimore Psychoanalytic Society met January 13 at the home of Dr. Edith Weigert. Dr. Olive C. Smith discussed "Handling a Stormy Analysis on One or Two Hours a Week," and Dr. Hilda Bruch read a paper on "Obsessive Neurosis with Phobia."

The Washington Medical and Surgical Society held a dinner meeting January 22 in the Pan American Room of the Statler Hotel, with Dr. Leonard Goodman presiding. Dr. George McLain presented a paper on "Burns" and Dr. George Tribble gave a case report. Dr. O. B. Hunter, Captain Alphonse McMahon and Dr. Daniel L. Borden participated in the discussion. A tribute was paid to Dr. Frank E. Gibson for his untiring efforts on behalf of the Society. About ninety members and guests attended the dinner.

The American College of Surgeons has placed its official approval on the following Washington hospitals: Children's, Columbia, Doctors, Casualty, Central Dispensary and Emergency, Freedmen's, Gallinger Municipal, Garfield, Georgetown University, George Washington University, Providence, St. Elizabeths, Sibley, Soldiers' Home, Veterans Administration and Washington Sanitarium. Two others, Episcopal Eye, Ear and Throat and National Homeopathic, were approved provisionally.

Among the 231 hospitals in the United States and Canada which have been approved by the College for graduate training in general surgery and surgical specialties are Central Dispensary and Emergency, Freedmen's, Gallinger Municipal, Georgetown University and Providence.

The local hospitals approved for residencies or fellowships by the Council on Medical Education and Hospitals of the American Medical Association are Central Dispensary and Emergency, Children's, Columbia, Episcopal Eye, Ear and Throat, Freedmen's, Gallinger, Garfield, Georgetown University, George Washington University, Providence, St. Elizabeths, Sibley, Veterans Administration and Washington Sanitarium.

Those approved by the Council for training interns are Central Dispensary and Emergency,

Doctors, Freedmen's, Garfield, Georgetown University, George Washington University, Providence, St. Elizabeths and Washington Sanitarium.

At the meeting of the **Executive Board**, December 23, **Dr. J. Ross Veal** was appointed one of the Society's two representatives to the District of Columbia Federation of Citizens' Associations. **Dr. Richard T. Sullivan** was appointed at a previous meeting.

Also at the December meeting of the Board, **Dr. Frederick O. Coe** was nominated to succeed himself as Vice President of the Washington Academy of Sciences, and **Dr. Fred R. Sanderson** was designated the Society's representative on the D. C. Nurse Recruitment Committee.

The Washington Urological Society elected new officers at its meeting December 21 at Doctors Hospital. They are:

Dr. Norvell Belt, *President*; Dr. Frederick C. Reuter, *Vice President*; Dr. G. Roland Gable, *Secretary*.

The District of Columbia Dental Society gave a Testimonial Dinner in honor of **Dr. Sterling V. Mead** in the Congressional Room of the Statler Hotel, January 17. Dr. Mead was recently elected President-elect of the American Dental Association, in which organization he has achieved recognition through his work as Chairman of the Legislative Committee.

Dr. Robert P. Fischelis, Director of the Division of Drugs, Chemicals and Health Supplies in the War Production Board's Office of Civilian Requirements, was elected Secretary and General Manager of the **American Pharmaceutical Association** by its Council, December 9. Dr. Fischelis took office January 1, succeeding the late Dr. E. F. Kelly.

Dr. Fischelis served as President of the American Pharmaceutical Association in 1934, following a term as Vice President. He was named Chairman of the Council in 1941, a post he held until the present time. In 1943 he received the Remington Medal, highest award in American Pharmacy.

The first issue of *Clinical Proceedings of the Children's Hospital*, a new bulletin in the medical field, was published in December, 1944. It contains an explanatory foreword by Dr. Joseph S. Wall, Chair-

man of the Medical Staff of the Hospital. The Editorial Staff consists of three members from the Medical Staff of the Hospital, Drs. Wall, E. Clarence Rice and Richard H. Todd; three members from the Resident Staff, Drs. Frederic G. Burke, John E. Cassidy and Mary P. Warner; eight Associate Editors from the Resident Staff; and a Secretary, Miss Dorothy Stefanik.

The bulletin is printed for the benefit of the present and former members of the Attending and Resident Staffs, and the clinical clerks of Georgetown and George Washington Universities.

Dr. Arnold McNitt has been named Councillor of the Southern Medical Association. **Dr. Oscar B. Hunter** is now Vice Chairman of the Section on Pathology of the Southern Medical Association.

Dr. Emil J. B. Hildenbrand was called by the American Medical Association to testify before the Federal Communications Commission hearing in Washington early in October, which hearing was held to determine future location of short wave diathermy field in a steadily enlarging communications and industrial short wave field.

At the meeting of the Southern Medical Association in St. Louis, November 13-16, Dr. Hildenbrand read a paper entitled, "Evaluation of Treatments in Thromboangiitis Obliterans (Buerger's Disease)." At the same meeting he presented an exhibit on "Thromboangiitis Obliterans Before and After Fever Therapy."

Colonel Joseph F. Siler has been reelected President of the Gorgas Memorial Institute of Tropical and Preventive Medicine, Inc.

Dr. Riley Henry Guthrie, who has been Assistant Superintendent of St. Elizabeths Hospital since 1939, and Professor of Psychiatry at Georgetown University School of Medicine, has been appointed Superintendent of the Norwich State Hospital, Norwich, Conn. He assumed his new duties February 1.

Dr. John A. White was recently appointed Chief Medical Examiner of the Pennsylvania Railroad Voluntary Relief Department, Philadelphia, succeeding Dr. Harvey Bartle. Dr. White is continuing as an Associate Member of the District Medical Society.

The Columbia Historical Society has presented the Medical Society with a portrait of its first President, the late **Dr. Joseph M. Toner**, eminent Washington physician of the seventies and eighties. The Society's Executive Board acknowledged the gift on behalf of the Society and expressed its gratitude.

A Special Building Committee was appointed by the Executive Board November 27, 1944 with instructions to proceed with the remodeling of the Society's building at 1710 M Street, N.W. Members of the Committee are as follows:

Dr. W. Raymond Thomas, *Chairman*; Drs. Henry R. Schreiber, J. Chester Brady, George R. Huffman, and Henry L. Darner.

Colonel A. Clagett Gray has been appointed by President Greear to succeed Lt. Colonel Stuart O. Foster as Chairman of the Committee on Service Physicians.

Dr. Addison Duval, Senior Medical Officer at St. Elizabeths Hospital, addressed a meeting of social workers, physicians and rehabilitation authorities, sponsored by the Council of Social Agencies, January 25. The theme of the meeting was "The Veteran Returns to Our Community."

Dr. Herbert H. Diamond has been appointed to the medical inspection staff of the public schools, according to an announcement made by the Health Department, January 5. Dr. Diamond has been assigned to inspect children in five elementary schools and one junior high school in the Southeast Section of the city.

Dr. Dorothy Donley Dowd was one of the speakers at the Second Annual Catholic Conference on Family Life, held at Catholic University, January 30 through February 2.

BOOKS RECEIVED FOR REVIEW

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis, vol. IV, 1943. New York: National Foundation for Infantile Paralysis, Inc., 120 Broadway.

Control of Pain in Childbirth. CLIFFORD B. LULL, M.D., F.A.C.S., Clinical Professor of Obstetrics, Jefferson

Medical College; Assistant Director, Philadelphia Lying-In Unit, Pennsylvania Hospital, AND ROBERT A. HINGSON, M.D., Surgeon, U. S. Public Health Service; Director, Postgraduate Medical Course, Philadelphia Lying-In Unit, Pennsylvania Hospital. Price, \$7.50. Pp. 341, with 132 illustrations. Philadelphia: Lippincott, 1944.

Marihuana Problems. MAYOR'S COMMITTEE ON MARIHUANA, George B. Wallace, M.D., *Chairman*; E. H. L. Corwin, Ph.D., *Secretary*. Price, \$2.50. Pp. 220. Lancaster, Pa.: Jacques Cattell Press, 1944.

Medical Uses of Soap—A Symposium, Edited by MORRIS FISHBEIN, M.D. Price, \$3.00. Pp. 182 with 41 illustrations. Philadelphia: Lippincott, 1945.

BOOK REVIEW

Synopsis of Neuropsychiatry. LOWELL S. SELLING, M.Sc., M.D., Ph.D., Dr. P.H., Director, Psychopathic Clinic, Recorder's Court, Detroit, Michigan. Price, \$5.00. Pp. 500. St. Louis: Mosby, 1944.

The life of the medical student is filled with vicissitudes and tribulations. The books he has to study are all no less than a thousand pages long and none weighs less than eight pounds. It is, therefore, gratifying to note the appearance of a textbook which fulfills all the requirements for completeness yet has the essentials of needed brevity.

The "Synopsis of Neuropsychiatry" is presented in a classified form which should appeal to the medical student, particularly one who wishes to have the needed information at the tips of his fingers. In the neurologic part, the various diseases are taken up by anatomic structure: the peripheral nerves, the spinal cord, the brain stem, and so on; followed at the end by the muscular system and the convulsive states. Of importance is the inclusion of the military and medicolegal aspects of the diseases. Thus, in the case of herpes zoster we have the statement that this condition occasionally arises in any large body of troops but that, unless the sight is impaired, the man may be returned to active duty in six weeks or less. In the instance of tetanus (page 293) it is stated that negligence may lie behind the wound, after which tetanus appears, justifying a claim. These are important practical points. Amazingly enough, although the material is very briefly presented, the author has managed to include a number of rarer neurologic conditions such as Erb's paralysis, as well as hereditary familial diseases.

On the psychiatric side, one is impressed with the remarkably brief, yet sufficiently explicit statement of the

problems of mental diseases. Even a precise statement of basic psychoanalytic concepts and mechanisms is included. Following this, the various diseases are taken up according to conventional and generally accepted classifications. Most interesting is a chapter on malingering which is especially important in these days because the condition is frequently observed in the Army. One also has to call attention to the chapter on parapsychosis, which term and description are original with the author.

The book is a welcome addition not only to the armamentarium of the medical student and the intern, but will also find a great usefulness in the office of any practicing physician. Since diseases do not occur in vacuo but are lodged in human beings that have brains that think and hearts that feel, there is hardly a disease that has not its neuropsychiatric aspects.

B. K.

MEETINGS

Wednesday, March 7

BUSINESS MEETING

Nominations for office; report of Executive Board

Wednesday, March 14

PREVENTIVE MEDICINE (15 min.): "Mental Hygiene," WINFRED OVERHOLSER, M.D., Superintendent, Saint Elizabeths Hospital

The Syphilis Journal Club will sponsor the following program:

1. "Newer Aspects in Venereal Disease Control," JOHN R. HELLER, JR., M.D., Chief, Division of Venereal Diseases, United States Public Health Service
2. "Penicillin Treatment in Syphilis," JOHN F. MAHONEY, M.D., Director, Venereal Disease Research Laboratory, Staten Island, New York
3. "Penicillin Treatment in Gonorrhea," C. JAMES VAN SLYKE, M.D., Assistant Chief, Division of Venereal Diseases, United States Public Health Service
4. "Serology in Syphilis," RICHARD C. ARNOLD, M.D., Associate Director, Venereal Disease Research Laboratory, Staten Island, New York

Wednesday, March 28

PREVENTIVE MEDICINE (15 min.): "Plans for Federal Employee Health Services," J. W. CRONIN, M.D., Senior Surgeon, United States Public Health Service

The following program will be presented by the *Washington Gynecological Society*:

1. "Ectopic Pregnancy," illustrated with lantern slides, H. HUDNALL WARE, JR., M.D., F.A.C.S., Professor of Obstetrics, Medical College of Virginia, Richmond
2. "How Safe Is Caudal Anesthesia?," GEORGE J. ELLIS, M.D., Instructor in Obstetrics, Georgetown University School of Medicine

FRANK EDWARD DEUHRING, M.D.
(1889-1945)

The death of Dr. Frank E. Duehring, well known Washington anesthetist, and an Active member of the Medical Society of the District of Columbia, February 2, 1945, came as a distinct shock to the medical profession of Washington. He was apparently in excellent health when he was stricken with a heart attack.

Dr. Duehring was born in Washington, D. C., on June 17, 1889, the son of Mrs. Anna Weide Duehring, who survives him, and the late Frederick W. C. Duehring. He attended Central High School and was graduated from the Georgetown University School of Medicine in 1912. He began the practice of medicine following his internship at Georgetown.

Dr. Duehring was Past President of the Georgetown Clinical Society. He was also a member of the Phi Chi Medical Fraternity, the American Society of Anesthetists, and the American Medical Association. He was a Fellow of the International Anesthesia Research Society.

During World War I Dr. Duehring served as a contract surgeon at Fort Myer, Virginia.

Surviving are his wife, Mrs. Elizabeth K. Duehring, and twin daughters, Mrs. Thomas F. Myers and Miss Virginia Atwill Duehring, and his mother, all of Washington. The Duehrings resided at 1830 Belmont Road, N. W.

ANTOINE SCHNEIDER, M.D.
(1905-1944)

Dr. Antoine Schneider, an Active member of the Medical Society of the District of Columbia, died suddenly at his home, 1218 Otis Place, N.E., Washington, D. C., on December 27, 1944.

Dr. Schneider was born in Washington, D. C., on June 2, 1905, son of the late Joseph Schneider, for many years librarian of Catholic University, and Mrs. Marie Schneider, who survives him. He attended the public schools of Washington, graduating from Gonzaga High School. He received his B.A. degree at Catholic University and attended Johns Hopkins Medical School, where he received his Doctor of Medicine degree in 1927. He interned at St. Elizabeths Hospital.

In the years 1928 and 1929 he was instructor in neuro-anatomy at the University of Rochester. From 1930 to 1932 he was resident in neurological surgery at Boston City Hospital. At the same time he was an instructor in neuropathology at Harvard University.

Since 1932 Dr. Schneider has been Professor of Neurology at Georgetown University School of Medicine. He was visiting neurologist at Georgetown and Gallinger Hospitals, and a member of the Commission of Mental Health for the District of Columbia.

Dr. Schneider was a member of the Medical Arts Society and the Louis Mackall Medical Society of Washington. He was also a member of the American Medical Association and the American Association of Anatomists.

Widely known to his friends as "Tony," Dr. Schneider was held in highest esteem by his colleagues. He was not only a capable physician but a fine gentleman as well.

Dr. Schneider is survived by his wife, Mrs. Colette Schneider, a daughter, Barbara, and his mother, all of Washington.

JAMES ALFRED ROLLS, M.D.
(1899-1944)

Dr. James A. Rolls, an Active member of The Medical Society of the District of Columbia, died on October 5, 1944, after a long illness. He resided at 1371 Hamilton Street, N. W.

Dr. Rolls was born in Watrous, New Mexico on January 10, 1899, the son of a doctor. He received his degree in medicine from the University of Michigan in 1923 and began practice in Washington following his internship at Providence Hospital.

Dr. Rolls is survived by his wife, Mrs. Ernestine Rolls, their three children, Ernestine Louise, Rosemary and Alfred, all of Washington, and his mother, Mrs. James Alfred Rolls, who lives in Santa Fe, New Mexico.

WILLIAM SMITH BEAN, M.D.
(1890-1944)

Dr. William S. Bean, Chief of the Hospital Division of the United States Public Health Service, died suddenly at his home, 7100 Meadow Lane,

Chevy Chase, Maryland, on November 26, 1944. He was 54 years of age.

Commissioned in the U. S. Public Health Service in 1915, Dr. Bean served in various capacities as Surgeon. He was medical officer-in-charge, successively, at the Marine Hospital, Mobile, Alabama; Pittsburgh; Norfolk, Virginia; and Baltimore, Maryland. He was appointed in June to the post in the Surgeon General's Office which he held at the time of his death.

Dr. Bean received his B.A. degree at Presbyterian College of South Carolina and his degree of Doctor of Medicine at the University of Virginia in 1915.

He was a member of the American Medical Association and the Association of Military Surgeons.

Surviving him are his wife, Mrs. Sophie Carlisle Bean, and four sons, Captain William S. Bean, Fresno, California; Aviation Cadet Howard Carlisle Bean, Corpus Christi, Texas; Midshipman George Adam Bean, now at the University of Notre Dame, and Aviation Cadet Joseph Sanborn Bean, at the University of Georgia.

CHARLES LEO DUGAN, M.D. (1889-1944)

Dr. Charles Leo Dugan, a former member of the Medical Society of the District of Columbia, died suddenly at Cincinnati, November 28, 1944.

Dr. Dugan was born in Washington, D. C., on January 17, 1889. He graduated from the Georgetown University School of Medicine in 1912. He obtained his license and began to practice medicine in the District in 1915. From 1912 to 1914 he was prison physician at McNeil Island Penitentiary.

At the outbreak of World War I he was commissioned first lieutenant in the Navy, afterwards being detailed to the Marine Corps. Following the war he established himself in practice in Washington, continuing here until last spring. At the time of his death, he was connected with the medical department of the Baltimore and Ohio Railroad in Cincinnati.

Dr. Dugan was a member of the Knights of Columbus.

He leaves two sons, Pvt. Charles L. Dugan, Jr., Tucson, Arizona, and Flight Officer James F. Dugan, Westover Field, Mass., and a sister, Mrs. Mary Dugan Mattare, of Washington.

(Lower Intestinal Tract—continued from page 56)

move the fibrous tissue of anorectal strictures, but it does lessen the rectal leukorrhea and the edema about the strictures so that patients may pass stools of fair caliber. Therefore, sulfonamides are given intermittently to all cases of stricture. As I see it, the mechanical dilatation of rectal strictures is a medical procedure unless a general anesthetic is required; then the surgeons are asked to help us. Extensive involvement of a long segment of the rectum or of the sigmoid, involvement which resists treatment with sulfonamides, is best treated by colostomy.

In this discussion of the medical aspects of 3 inflammatory lesions of the colon I have tried to point out that their therapy is primarily medical but that it may become surgical and that in them, as in so many other conditions, coöperation between the internist and the surgeon is desirable.

(Diabetes Tomorrow—continued from page 69)

from May 1923 to August 1940, the mortality was 12 per cent. When the insulin given in the first 3 hours of treatment was increased from 83 units in 1923-1927 to an average of 216 units among 123 consecutive cases treated between August 1940 and May 1, 1944, the mortality was only 1.6 per cent.

2. Diabetic coma is an emergency due to acute insulin deficiency requiring administration of adequate, often large doses of insulin in the first 3 hours.

3. Estimation of the insulin requirement is difficult, because (a) insulin resistance increases hourly with acidosis and (b) the law of diminishing returns applies to insulin.

4. Treatment should be carried out in a hospital. The consultant in diabetes or a senior staff member should be consulted within the first hour after admission, since it is unfair to patient and doctor to leave the decision as to treatment in such an emergency to a young resident staff member.

5. Important aids in treatment are (a) the use of normal saline solution intravenously or subcutaneously (4,000 c.c.), or when necessary to overcome shock and impending anuria, up to 10 per cent or even 15 per cent of body weight, and (b) gastric lavage.

6. The harmful effect of glucose administration may be concealed in early diabetic coma by the insulin simultaneously administered; the moderate case of coma may be converted into a severe one requiring excessive insulin dosage. In advanced coma, glucose administration either by mouth or by needle may cause anuria and death.

7. Diabetic gangrene is influenced greatly, both as to incidence and outcome of treatment, by the type of treatment employed in the years preceding its onset.

8. There has been improvement in the results of treatment in juvenile and pregnant diabetics.

(MEDICAL CARE—continued from page 89)

1941 and built up a small circulation of about one thousand. Many persons deeply interested in the socioeconomic aspects of medicine read this journal. Even though they did not agree with the views and objectives of its sponsors, they found them stimulating.

There is still room for differences of opinion as regards the delivery of medical care. Certainly this is no time for intolerance.

(Psychoneuroses—continued from page 75)

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Cast Your Ballot

The election procedure adopted by the Medical Society last year will be followed in 1945. Ballots on which are listed candidates for the Nominating Committee were mailed to the Society's membership on January 15. A week or ten days prior to that date, ballots were sent to members in the armed services in this country and overseas.

The selection of candidates for the Committee was made by the Society's President with the utmost care on a geographic basis. Other factors, such as type of practice and hospital affiliations, were also taken into account so that choice could be made from a representative group. It is hoped that every member eligible to vote will take advantage of his franchise.

The seven physicians receiving the most votes will be declared members of the Nominating Committee, the highest automatically becoming Chairman. The Committee will select not less than two candidates for each office. Nominations will be submitted by the Committee at the business meeting of the Society to be held on March 7. Nominations can, of course, be made from the floor.

Do your duty — cast your ballot.

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DELAYED RUPTURE OF THE SPLEEN

Report of a Case and Discussion of Mechanism

THOMAS BRADLEY, M.D., F.A.C.S.

Major, Medical Corps, Army of the United States

THE following case is reported because it is believed that some of the clinical features encountered during the care of this patient are of interest, and a suggestion concerning the mechanism of delayed splenic rupture is made.

REPORT OF CASE

An air crew trainee, aged 23, white, single, and in perfect health, having recently met the physical requirements for flying training in the U. S. Army, made a crash landing on September 17, 1943. Deceleration of the plane from about 100 m.p.h. to 0 took place in 4 phases, striking successively one wing on the ground, an auto top, the cabin of a Coca-Cola truck, and finally the hangar. The patient was seated with a single strap safety belt fastened across the pelvis, allowing the body torso to swing forward against a small table placed in front of him for making calculations. The plane made a swing to the right causing his lower chest to bump the table. He could recall bleeding from either his chin or mouth, did not lose consciousness and remained in the plane because of pain in the left shoulder and the bleeding. It became apparent that the plane was burning, and he jumped out after receiving severe burns of the entire face, both hands, arms, buttocks and parts of the ankles and legs. Treatment in the Station Hospital consisted of the administration of blood plasma and morphine to combat shock. Pressure dressings of vaseline gauze

were applied to the burns after dusting with sulfadiazine powder. During the next month his general condition improved greatly and his burns healed without necessitating plastic surgery, but he continued to complain occasionally of pain in the left chest and abdomen. Numerous X-ray films were made which were reported as showing fractures of the third and fourth ribs on the left side. With bed rest all symptoms improved so that on December 20, 1943, after 94 days of hospitalization, he was feeling perfectly well and was discharged on a furlough. He came to Houston, Texas for part of his vacation.

On January 11, 1944, 116 days after his accident (slightly less than 4 months) he stated that while feeling perfectly well he had had a sudden acute illness characterized by an abrupt onset of weakness and a sudden desire to defecate. This was accompanied by profuse sweating, a feeling of faintness, nausea, vomiting of breakfast eaten several hours before, and a transient mild pain in the left shoulder. He recovered from this attack for about 2 hours, when a sudden severe pain developed in the right upper quadrant accompanied by profuse vomiting of bright red blood and collapse. A physician was called who stated that he was in shock with extreme pallor, profuse sweating, boardlike rigidity of the right upper quadrant with local tenderness confined to the right upper quadrant, and a rapid weak thready pulse. He was immediately admitted to a civilian hospital where routine laboratory work was reported as follows: hemoglobin 60 per cent (Sahli), red blood cell count 3,580,000, and white blood cell count

16,600, with 74 per cent polymorphonuclear neutrophils. The urine was normal. Conservative management was instituted; 1,500 c.c. of blood plasma was administered, and the patient improved slightly. The following day blood counts were repeated revealing 54 per cent hemoglobin (Sahli), red blood cell count 2,800,000, and white blood cell count 8,600, with 74 per cent polys. I then saw the patient for the first time following what was said to be considerable improvement. The respiratory rate was 28 per minute, the pulse rate was 100 per minute, and the temperature was 98.6°F. The patient was pale and sweating slightly; the abdomen was diffusely and slightly tender, definitely more marked in the right upper quadrant with slight distention and shifting dullness in both flanks. The heart and lungs were normal, the blood pressure 110/80. He was given 2 blood transfusions of 500 c.c. each, and at the end of 4 days he had improved sufficiently to be transferred from the civilian hospital to the Regional Station Hospital at Ellington Field, where he continued to improve. On January 20, 1944, 10 days after his acute episode, his pulse and temperature, which had been normal since admission, became slightly elevated after an extremely uncomfortable night from pain in the neck on the left side. On physical examination to determine the cause for this pain and temperature it was noticed that the left diaphragm failed to descend normally by percussion, and that there were a few moist râles at the base of the left lung posteriorly. There was also faint jaundice of the sclerae. Fluoroscopy revealed elevation and marked limitation of motion of the left leaf of the diaphragm. Plain films of the abdomen and chest were made. These examinations revealed consolidation at the left base, and in addition the splenic flexure of the colon was displaced downward by an ill-defined extrinsic mass. The stomach gas bubble was displaced medially and the diaphragm upward. These films had been developed immediately, and during their examination, while they were still wet, word came that the patient was having another acute severe attack of upper right abdominal pain. On examination there was obvious shock with profuse sweating. The pulse rate was elevated to 160 per minute, and the respirations, which were entirely costal in type, were short, quick and accompanied by an expiratory grunt. There was marked tenderness in the upper right quadrant with boardlike rigidity of the upper abdomen. Elsewhere the abdomen was not tender. A blood count done that morning just prior to his X-ray examination was recorded as follows: red blood cell count 3,860,000, hemoglobin 10.0 Gm., and white blood cell count 16,800, with 88 per cent polys. Because of this secondary anemia and the patient's desperate condition 3 donors were bled, a continuous trans-

fusion was started, and immediate laparotomy through a high right rectus incision under spinal novocain-pontocaine mixture was carried out, under the impression that we were dealing with a second perforation of a duodenal ulcer with a left subphrenic abscess.

On opening the peritoneum a large amount of old dark blood was found filling the entire peritoneal cavity. The lesser curvature of the stomach near the pylorus on the anterior surface presented definite scarring with a few firm adhesions and some thickening of the peritoneum. No perforation could be made out. For the first time the diagnosis of delayed splenic rupture suggested itself, and an attempt was made to explore the spleen manually. The splenic flexure of the colon was adherent anteriorly, so that the spleen could not be palpated readily. The incision was then enlarged to the left dividing the rectus muscle transversely thus gaining access to the left upper abdomen. After considerable difficulty the spleen was identified and was found to be firmly adherent to the diaphragm, stomach, pancreas, and splenic flexure of the colon, and was surrounded by old organizing blood clots. The various ligaments of the spleen were all heavily infiltrated with dark blood and were thickened and fibrotic. The spleen itself was ruptured anteriorly near the notch with a tear extending toward the hilus. The spleen was removed in 3 pieces, 1 main body and 2 smaller fragments. Practically no fresh bleeding was encountered from the site of the rupture. The removal was extremely difficult because of the adherence of the capsule of the spleen to the diaphragm. The splenic capsule was left attached to the diaphragm and a cleavage plane was developed along what apparently had been a subcapsular hematoma, although accurate identification of tissue at this point was difficult. Two large fresh blood clots the size of a man's fist were slightly adherent to the inner half of the left diaphragm. The patient responded dramatically to the administration of a 1,500 c.c. blood transfusion given during the course of the operation, and the abdomen was closed without drainage after dusting the cavity remaining after splenectomy with 5 Gm. of sulfanilamide powder.

Postoperatively he made a smooth convalescence for about 3 weeks and then developed a left subphrenic abscess from which *Staphylococcus aureus* was recovered repeatedly in pure culture. This abscess was drained through the outer end of the transverse abdominal incision and penicillin solution instilled, with complete recovery. An upper gastrointestinal X-ray examination made before discharge did not show a gastric or duodenal ulcer, but did reveal a notching inward of the fundus of the stomach as of something pressing on the fundus. This was thought to be due to scarring from the presence of the drainage tract of the subphrenic abscess.

Pathologic studies of the material removed were made at the School of Aviation Medicine at Randolph Field, Texas. The pathologist reported as follows:

"Several sections of the spleen and of fragments described previously show several minor changes in the pulp of the spleen, partially organized blood clot and scar tissue. The changes within the pulp of the spleen are local in distribution. These consist of fibrinoid or hyaline masses of intercellular material which is restricted to the central areas of the germinal follicles. Where these deposits are found, the small arteries and arterioles show an unusual degree of thickening and hyalinization of their walls. There is no associated hemorrhage or inflammation. The principal part of the splenic pulp, however, is normal. In the subcapsular areas there are interesting acute or subacute changes which are characterized by an infiltration with polymorphonuclear leukocytes and proliferation of fibroblasts with formation of collagen. It seems likely that the process in these local areas is of no greater than 2 or 3 days' duration. This is referable, in all likelihood, to the recent exacerbation of symptoms prior to surgical exploration. In one or two sections there is also involvement of the capsule by fibroblastic tissue which seems to be of greater age than that described above. This tissue can be traced into partially organized blood clot. At no point is there any evidence of infection or of partial localization of an infectious process. Neither is there any pancreatic tissue in any of the sections. No thrombosed vessels are found. Diagnoses: acute and subacute subcapsular and extracapsular splenitis with organization; organization of blood clot adjacent to the spleen; hyalinization of arterioles and follicles of the spleen; traumatic rupture of the spleen (clinical)(?)."

In retrospect with further investigation it was found that the patient had never "vomited profuse amounts of blood" but had vomited blood-streaked material after about an hour of vomiting. This information was difficult to obtain but was finally verified. The patient now states that the greatest difficulty he had during the latent period was inability to eat as rapidly as other people. If he ate quickly nausea would ensue, but if he ate slowly he could eat a large meal. There was pain in the left abdomen and left shoulder which at times was sharp and at other times would disappear. Immediately preceding the onset of his illness after the interim of 4 months he had been very anxious to get to town and was somewhat excited over the prospects of a good time ahead. There was no history of malaria, and he had never been in the tropics.

DISCUSSION

Delayed rupture of the spleen occurring acutely nearly 4 months after the injury is very

rare. I have been unable to find a case in the American literature with a latent period of this length of time. Most frequently delayed rupture of the spleen occurs between the third and ninth day after trauma which may or may not be trivial. Those cases in which the hemorrhage continues, leading to dangerous anemia before 48 hours, are not considered as delayed rupture of the spleen, but they constitute the majority of cases reported of splenic rupture.

Zabinski and Harkins¹ reported 179 cases of delayed rupture of the spleen with a latent period varying from 5 hours to 2 years. It is seen that there is great variation in this latent period, and they cite 8 theories to explain the mechanism. These are briefly:

1. Temporary hemostasis produced by shock; further hemorrhage followed by recovery.
2. Hematoma under tension. Pressure of hematoma causes bleeding in spleen to cease.
3. Theory of subcapsular hematoma. Capsule becomes elevated, blood collects beneath the capsule and eventually ruptures through.
4. Formation of clots at the laceration. Clots in various stages of organization have been observed frequently. This extrasplenic clot is readily detached by a minimal effort.
5. Tamponade by omentum.
6. Tamponade by stomach, colon or adhesions.
7. Theory of perisplenic hematoma. Hemorrhage from the injury surrounds the spleen, elevates the diaphragm and displaces the splenic flexure of the colon downwards. Adhesions are formed producing an enclosure which does not permit peritoneal flooding.
8. Theory of threshold of hemorrhage. A threshold exists at which signs of hemorrhage appear. Previous to reaching this limit no signs appear.

Some of these factors certainly play a part in explaining the clinical picture seen. They do not

explain the mechanism whereby following a relatively trivial injury, such as a blow from a milk bottle, there will be transient pain with recovery and the patient able to resume his normal activities, when, after a week or 10 days, severe hemorrhage from the spleen follows with a fatal outcome unless immediate splenectomy is performed.

In 1925 Barcroft^{2,3} pointed out from CO absorption experiments that there was a strong possibility that the human spleen acted as a reservoir for red cells and injected them into the circulation on demand from hemorrhage, change in altitude, strong emotion, or in response to peripheral vasodilatation during hot weather. There is no question concerning the contractility of dog and cat spleens since this has been verified many times by different workers. The human spleen has been seen to contract by surgeons when removing the spleen after injection of adrenalin for Cooley's anemia in children. This fact apparently has never been published. Further evidence that the spleen acts as a reservoir in humans is presented by Wu,⁴ who perfused human spleens with tap water and found that they were capable of quite marked increase in volume without rupture. This work was done on fresh human spleens removed post mortem, and 1 in his series increased in volume by 400 c.c. Although Wu's work is not conclusive, it does add strong evidence that the human spleen contracts.

With these factors in mind the sequence of events in the case here reported could be explained as follows. At the time of the crash the patient was thrown forward against the table sustaining a relatively small laceration of the anterior extremity of the spleen. There was immediate bleeding with the formation of a perisplenic hematoma. Morphine and plasma for his burns tided him over the acute stage and the perisplenic hematoma walled itself off but tended to slowly enlarge with fresh hemorrhage brought on by splenic contractures from time to time. During these episodes there would be transient

pain in the left side. As time went on the diaphragm became elevated, the stomach was displaced to the right, and the splenic flexure of the colon was displaced downward. Compression of the stomach forbade the eating of a large meal but allowed small amounts at a time to pass by readily. Eating as rapidly as normal caused a pain in the left lower chest in this case. Eventually the perisplenic hematoma ruptured into the peritoneum across the anterior surface of the stomach. The scarred area on the pylorus could be the site of the rupture. This would explain the right-sided abdominal pain. Quite a few other operators have made the same mistake of confusing these cases with perforated duodenal ulcers, since the onset is equally sudden with severe pain in the upper right quadrant and shock. Many of the reported cases have ruptured into the peritoneum on the left side.

It is possible to make the diagnosis during the latent period, but few have been this fortunate. Elective surgery during the latent period would surely give better results than emergency surgery during the period of rupture of a hematoma. The mortality rate from these cases unoperated is reported by various authors as varying from 100 to 70 per cent. Several cases have been operated on and packed, with subsequent death. The operative mortality of splenectomy in these cases is approximately 20 per cent, leaving but little choice as to the proper therapeutic procedure. During the latent period the following signs and symptoms should be helpful in making the diagnosis.

1. History of trauma with or without fractured ribs on the left side.

2. Increased splenic dullness.

3. Transient pain in the left shoulder (Kehr's sign). This sign is often absent during the latent period but when present would help.

4. Shifting dullness in the flanks, i.e., fluid in the abdomen. Ballance's sign is shifting dullness in the right flank but not in the left, and is supposed to be a strong indication of a ruptured spleen. This sign is repeatedly quoted in the

literature but is not often recorded as being present in a given case. Whether this is due to lack of observation or failure of the sign to be present is not clear.

5. Elevation of the left diaphragm either to the same height or higher than the right. To check this point 1,000 normal chest films were reviewed. The inner end of the left diaphragm was consistently lower than the right provided that it was not elevated by the gas bubble of the stomach.

6. Failure of descent of the left diaphragm during inspiration as determined by percussion and checked by fluoroscopic examination; repeated plain films of the upper abdomen showing the splenic flexure displaced downward, the gas bubble of the stomach displaced medially, and the diaphragm upward.

7. Bouts of pain in the upper left abdomen and side after eating associated with inability to eat rapidly.

8. Persistent mild anemia.

9. Mild jaundice not obstructive in type.

The late results of splenectomy have been reported as elevation of the platelet count which I was able to confirm in this case. Leukocytosis has been variable but slightly elevated. There has been a persistent mild evening elevation of fever to 99.4°F. since operation. The patient states that he is now able to eat without pain but still eats slowly.

Recently 6 different authors have reported finding splenic implants spread over the peritoneum years after rupture of the spleen. These consisted of typical splenic pulp, serosal capsule and well-defined Malpighian bodies. If splenic implants or accessory spleens were present following traumatic rupture it would be reasonable to assume normal blood findings following removal of a ruptured spleen.

SUMMARY

A case is reported of delayed rupture of the

spleen occurring nearly 4 months after injury. A suggestion concerning the mechanism of delayed rupture of the spleen is presented. X-ray examinations of the diaphragm and upper abdomen were made about 1 hour prior to the second delayed rupture of the spleen. The theory is advanced that one of two events takes place which will explain the clinical features of these cases:

1. A subcapsular or intrasplenic hematoma forms as a result of the initial trauma without actual rupture of the capsule. Following strong physiologic contraction at a later date the spleen might "burst" with resultant serious fresh hemorrhage and a fatality. This could be the sequence of events in those cases of delayed rupture of about 10 days following apparently trivial injury.

2. A perisplenic hematoma could slowly build up following the initial trauma, consisting of a relatively small tear involving only the capsule and smaller arteries. As this hematoma enlarges from repeated hemorrhages due to repeated contractions of the spleen, the patient would experience various types of discomfort, such as pain in the left upper abdomen, left shoulder, nausea, etc. The hematoma would tend to become organized but would eventually enlarge to such an extent as to produce the picture seen in the X-ray films of this case taken immediately after rupture of the perisplenic hematoma.

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THYROTOXICOSIS IN A CHILD MANAGED WITH THIOURACIL

Report of a Case

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TOXIC goiter is a relatively uncommon occurrence in children. At the Crile Clinic,¹ in Cleveland, there were but 42 cases in children under 14 years of age in a series of 13,200 cases of hyperthyroidism. The Mayo Clinic² reported 157 cases of exophthalmic goiter in children 14 years or less, among 15,505 cases seen at that institution, an incidence of slightly more than 1 per cent. This latter series of cases, reported by Roger L. J. Kennedy, comprises the largest and most reliable set of statistics of this disease in children. One hundred thirty-six of the cases reported by Kennedy were treated surgically after a preoperative course with Lugol's solution, most of whom had been given a trial on a medical regimen. In childhood, obviously, a successful medical management of this disease would have tremendous advantage because of the important role the thyroid gland plays in development. Most workers agree that, in spite of the best medical care and treatment, surgery is found necessary in the vast majority of cases.

Kerley³ gave medical measures a trial of at least 1 year before advising surgical interference. In his report of 104 cases of hyperthyroidism in children, the majority, eventually, were treated surgically.

Reilly⁴ reported operative treatment in 55 per cent of the 62 patients he treated over a period of 10 years after failure of a medical regimen to control the toxicity of the disease.

Despite the importance of the thyroid hormone in the growth and development of the child, thyroidectomy has been necessary in the success-

ful management of toxic goiter in most of these patients. A low percentage may be successfully treated by bed rest, the judicious use of iodine, psychotherapeutic and other medical measures, but nearly all reports agree that removal of the gland is eventually necessary in the majority of cases.

Not too much information is available regarding the detailed follow-up of children who have had a thyroidectomy. A recurrence rate of approximately 8 per cent is a generally accepted figure, and hypothyroidism and hypoparathyroidism are not rare complications. Kennedy reported a reduction in the surgical mortality rate of toxic goiter from 9 to 2.5 per cent due to the use of iodine. The operative mortality rate throughout the country, however, is probably higher.

The recent literature contains many reports concerning the effectiveness of thiouracil in the treatment of hyperthyroidism in adults. This drug has been used in approximately 2,000 cases up to the present time in this country, and there is uniform agreement upon its beneficial influence in thyrotoxicosis. Recent investigations have centered more upon the toxic effects of this drug, especially as it affects the hemopoietic system. There have been 7 known deaths due to agranulocytosis and leukopenia attributed to this method of treatment. However, in well controlled series, such as reported by Williams and Bissell,⁵ and others,^{6, 7} no serious toxic results have been noted. It appears, therefore, that an extremely valuable addition has been made to the medical armamentarium for the treatment of hyper-

thyroidism. It is not possible to state whether patients may be controlled indefinitely with this drug, but it would seem an extremely advantageous procedure to be followed in children with this disease in consideration of the relatively more important role of the thyroid gland to these subjects.

The case reported here indicates, at least, the value of thiouracil in bringing about a remission of the toxic symptoms of hyperthyroidism for an indefinite period of time. While surgical removal of the gland might become an eventuality, it is believed that the longer this can be delayed the more this patient will benefit.

REPORT OF A CASE

D. H. (44-5431), a colored female, aged 10 years, was admitted to Children's Hospital on July 19, 1944 with the chief complaint of "puffiness of the neck." About 2 weeks before admission the child's mother had noticed a swelling of the anterior portion of the neck which had increased in size. The mother stated that she had been impressed by her daughter's eyes having a "staring" expression and appeared to bulge. This characteristic was most marked in the mornings, upon awakening. Concomitantly, the child developed a voracious appetite and despite this had lost weight. The exact amount of weight loss was not known. The child had become extremely "nervous" and "irritable." She had vomited on several occasions without apparent provocation. Dyspnea was noted upon exertion, and a doubtful history of palpitation of the heart was elicited. There had been no evidence of peripheral edema.

The child's past medical history was irrelevant. The maternal grandmother had been operated upon for "goiter" at the age of 45. The mother and father had no signs or symptoms of thyroid disease. A review of the systems was essentially normal. The patient had not yet begun to menstruate.

The patient was slender and well developed, in no apparent distress, and quite alert. There were no skin lesions or evidence of lymphadenopathy. The pulse rate was 120 per minute, the respiratory rate 16; the blood pressure was 150/60 in both arms. There was a mild degree of exophthalmos with a suggestive lid lag. The thyroid gland was asymmetrically enlarged, the left lobe being slightly smaller than the right. The right lobe measured approximately 6 by 3 cm. and the left lobe approximately 5 by 2 cm. The gland was firm and smooth. There were no nodules palpable. This mass

moved with deglutition and was not tender. No bruit was heard. The lungs were apparently normal. The apical impulse was diffuse with a suggestion of a thrust. The rhythm was slightly irregular because of frequent extrasystoles. No murmurs were present. The abdomen was normal, and the extremities were normal, except for a fine tremor upon extension of the upper extremities. Quadriceps weakness was elicited by the stair-climbing test. Neurologic examination was essentially normal.

During the first 2 weeks in the Hospital, while under observation, exophthalmos of a mild to moderate degree with infrequent blinking and stare were noted. The patient complained of choking sensations which were probably related to the cervical mass. Her skin was noted to be moist and warm, and a functional apical systolic murmur became manifest. Despite a good appetite, on a regular diet, the patient's weight decreased from 72 lbs., 4 ozs. to 71 lbs., 12 ozs. At the end of 8 days, upon continued bed rest, her weight picked up and at the end of 2 weeks she weighed 74 lbs., 4 ozs. Her pulse rate during the first week averaged 126 per minute, and her blood pressure at the end of 2 weeks in bed was 138/80. The basal metabolic rate 4 days after admission was plus 29 per cent and 2 days later 41 per cent. The blood cholesterol was 173 mm. per 100 c.c. The sedimentation rate was 17 mm. per hour (Wintrobe and Landsberg method). Inorganic phosphorus of the blood was 5.3 mm. and the calcium 10.4 mm. per 100 c.c. Repeated urinalyses and blood counts were essentially normal. An X-ray film of the chest on the day after admission revealed the heart to be moderately enlarged to the left and right. One of the skull was reported as negative. An electrocardiogram taken on the eighteenth day after admission revealed only sinus tachycardia.

On August 3, 1944 the patient was placed on thiouracil (Deracil, Lederle Co.*) and was given doses of 0.10 Gm. 3 times a day for 4 days. The dose was then reduced to 0.10 Gm. twice a day for 8 days and was then discontinued because of toxic symptoms. These were manifested by ringing in the ears, nausea and vomiting, rapid pulse, severe headache, and slight fever (101°F.). After 24 hours the drug was given again in doses of 0.10 Gm. once a day. No further toxic symptoms were noted. Her blood pressure fluctuated between 150/100 and 115/70 during the first 2 weeks while on this treatment but thereafter was normal. A basal metabolic rate determined on August 10, 1 week after thiouracil was started, was plus 34 per cent and repeated on August 16, 2 weeks later, was a minus 6 per cent. Blood cholesterol on August 8 was 193 mg. per cent. An electrocardio-

(Continued on page 138)

* The thiouracil used in this case (Deracil) was kindly furnished by Lederle Laboratories, Inc., Pearl River, New York.

POLYCYTHEMIA VERA

Report of a Case in a Young Man and Review of Recent Literature

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POLYCYTHEMIA vera (Vaquez-Osler's disease, or erythremia) is a disease manifested by an increase in blood volume, erythrocythemia, splenomegaly, dyspnea, plethora, and a tendency to bleed abnormally. The disease is usually one of middle age and terminates fatally within 10 to 15 years. The discovery of polycythemia vera in a young man prompts this study.

REPORT OF CASE

The patient, a white male soldier, aged 24 years, was first admitted to the hospital, July 19, 1943, with osteomyelitis of the right scapula. His family history and previous history were noncontributory. Sulfonamides were administered (194 grams during his 3-month stay in the hospital), the abscess was drained, and later a sequestrum was removed. There was an intermittent fever for over 2 months. He was returned to duty on October 15, 1943. In the light of subsequent developments it is interesting to note that the hemoglobin was 104 per cent on admission and varied between 90 and 111 per cent throughout the period of hospitalization. No erythrocyte counts were done.

On March 23, 1944, he was readmitted for the purpose of excising a persistent sinus secondary to the osteomyelitis. Questioning elicited the information that at his induction 2 years previously, the examining physician remarked that he looked "sort of blue" and asked whether he had been taking sulfanilamide. The patient stated that for several years he had become fatigued easily, had had dyspnea, and had bled excessively when cut. On examination it was noted that the complexion was actually bluish. There was no splenomegaly and except for the draining sinus the physical examination was negative. The hemoglobin estimation (Sahli) was 140 per cent, the erythrocytes numbered 7,150,000, and the leukocytes 7,100 per cu. mm. of blood, of which 73 per cent were neutrophils, 24 per cent lymphocytes, 2 per cent monocytes and 1 per cent eosinophiles. The hematocrit read-

ing was 55 per cent and the volume index 0.73. The blood was abnormally viscid; the sedimentation rate, erythrocyte fragility test, bleeding and clotting times, icterus index, roentgenogram of the chest, electrocardiogram, and urinalysis were all normal. The basal metabolic estimation was -5 per cent. Rechecks of the blood count have shown no significant change.

DIFFERENTIAL DIAGNOSIS

The conditions that produce permanent cyanosis with an elevated erythrocyte count are emphysema, congenital heart disease, Ayerza's disease (sclerosis of the pulmonary arteries), chronic poisoning by various chemicals, repeated small hemorrhages, polycythemia resulting from high altitude, and polycythemia vera. Emphysema was ruled out in this case by the normal roentgenogram of the chest. Congenital heart disease and Ayerza's disease were eliminated by the normal roentgenogram of the chest, the normal electrocardiogram, and the absence of typical physical findings. Chronic poisoning by carbon monoxide, arsenic, phosphorus, manganese and the coal tar products was ruled out by questioning. There was neither history nor physical findings suggestive of repeated small hemorrhages. The patient is not an aviator and has never lived at high altitudes, so that secondary polycythemia did not have to be considered. Polycythemia vera was diagnosed.

REVIEW OF THE LITERATURE

In 1892 Professor H. Vaquez¹ of the Faculté Médecin, Paris, reported a patient with peculiar cyanosis and persistent polycythemia which he regarded as due to congenital heart disease.

The liver and spleen were enlarged and the erythrocytes and hemoglobin were greatly increased. On the death of this patient 3 years later no organic heart involvement was found. Vaquez did not draw conclusions about the patient but presented a factual report.

Following this initial description other cases were reported in Continental Europe and in this country, but it was not until 1903 that Osler,² in a classic paper, definitely established the condition as a disease entity. Other cases were reported by Osler,^{3, 4} in which he stressed the theory, which Lucas⁵ attributes to Turk, that the disease was due to primary hyperplasia of erythroblastic bone marrow. In 1905, Weber⁶ first reported increased blood volume as an essential feature of the condition. He also postulated that the splenomegaly might be a compensatory enlargement in an attempt to increase the blood destruction concomitantly with the increased blood production.

Hutchinson and Miller,⁷ in 1906, reported a case in which necropsy findings revealed tuberculosis of the spleen. This they believed may have been the basic cause, although their description of the organ is not typical of splenic tuberculosis. The theory that tuberculosis of the spleen is an etiologic factor was suggested in many cases reported during the following 5 years. Hutchinson's and Miller's case was the first one reported in English in which skin lesions were a predominant finding.

Lucas,⁵ in 1912, in an exhaustive study, reviewed the 189 cases which had been reported up to that time. He emphasized that the bizarre clinical picture presented led to diagnostic errors. He also discussed the various therapeutic methods and concluded that the prognosis was uniformly fatal in 10 to 15 years regardless of treatment.

During the next 20 years a number of case reports appeared but little new information was added. Additional symptoms were described and new treatments were suggested which soon proved valueless. In recent years, however, new

interest has been aroused by investigations, and our knowledge of the subject has increased.

CLINICAL PICTURE

Probably nothing in the recent literature concerning the clinical picture has added to our knowledge anything not known to Osler⁴ and Weber⁶ before 1910. The classical symptoms and signs are plethora (which has been variously interpreted as cyanosis or erythrosis), splenomegaly, bleeding tendencies, increased erythrocyte count, increased hemoglobin, and increased blood volume. The disease tends to run an asymptomatic course for years, and finally, as Rosenthal⁸ pointed out, becomes complicated by leukemia, thrombocythemia, anemia, or various combinations of these or all of them. Thus the late symptoms are varied and are dependent on local vascular lesions. Hemorrhagic or thrombotic lesions are most frequent in the central nervous system, and a great many neurologic disturbances have, therefore, been reported as complications. Brockbank,⁹ in 1929, reviewed the various types of neurologic complaints. The same sort of lesions is also found in the gastrointestinal, cardiovascular and urinary systems.

Tinney, Hall and Giffin^{10, 11} studied records of 163 patients observed at the Mayo Clinic and showed that there was a positive correlation between the duration of the polycythemia, the degree of splenomegaly and the presence of a leukemoid reaction. They stated that in the absence of severe cardiac decompensation in any of these patients, 65 showed a blood pressure of over 150 systolic, 15 over 180, and 2 above 200. Coronary sclerosis was present in 10 cases.

The course of the disease is variable, but no report has yet been made of a patient surviving more than 15 years regardless of therapy. Death may result from thromboses, hemorrhages, anemia, or intercurrent infection.

TREATMENT

There is a lack of uniformity of opinion concerning methods of treatment. The early treat-

ment by venesection is still employed. Hines and Darnall,¹² in 1943, advocated the use of repeated venesection in the control of polycythemia. Venesection, even though not the most effective form of treatment, does have the advantage of safety while achieving relief of symptoms.

Roentgen therapy over the splenic area was recommended early, but Avery,¹³ in 1930, held that excessive irradiation over the spleen may increase polycythemia by interfering with the splenic function of erythrocyte destruction. According to Pierson and Smith,¹⁴ the use of "spray X-ray" therapy (total irradiation of the body) was first suggested by Teschendorf in 1927, and numerous authors since then have advocated the use of this treatment.

Owen,¹⁵ in 1924, first reported the use of phenylhydrazine hydrochloride to produce sufficient hemolysis to maintain a normal erythrocyte level. Giffin,¹⁶ in 1936, suggested that the drug might even have an antihematopoietic effect, but warned that it should be given only to patients in whom the diagnosis was proved by the finding of an increased blood volume. He¹⁷ added, however, that death might result from excessive hemolysis or multiple thromboses following administration of the drug. McAlpin and Smith¹⁸ report that acetylphenylhydrazine is more effective and less toxic than phenylhydrazine hydrochloride. Recently Cruz¹⁹ has shown that the iron liberated from erythrocyte destruction by phenylhydrazine is promptly re-utilized to form new hemoglobin. Cruz definitely discounts the value of the drug.

Erf and Lawrence,²⁰ in 1941, using radiophosphorus injections, were able to relieve symptoms and reduce erythrocyte counts in 6 patients who had been refractory to other forms of treatment. In a second paper,²¹ in 1943, they reported clinical control in 11 additional cases. The use of this drug is still too new to be well evaluated, but it gives promise of being more successful than any previous form of therapy.

Colloidal lead administered intravenously was

suggested by Falconer,²² who reports control of symptoms, but its use is attended by considerable danger. Forkner and his associates²³ used potassium arsenite solution orally and claimed for it both safety and effectiveness over long periods of time. Weber,⁶ in 1905, tried and rejected arsenic as being non-effective, and Fitz,²⁴ in 1942, stated that his use of it had been unsuccessful.

A bizarre method of treatment was suggested in *Press Medicale* in 1942 and referred to in "Queries and Minor Notes" in the *Journal of the American Medical Association*²⁵ in 1943; this consisted in the application of hookworm larvae to the skin in an attempt to produce a hookworm infestation which could later be controlled with anthelmintics. Unfortunately, hookworm infestation frequently resists treatment and does not always produce anemia.

The use of iron-deficient diets has received little mention in the literature. Lucas⁵ dismissed its use as unsatisfactory but Dameshek and Henstell²⁶ found its use at least an important part of the treatment. The problem of devising an iron-free diet is a considerable one.

ETIOLOGY

There has always been a great deal of interest in the etiology of this condition. Lucas⁵ refers to the fact that Belanovsky demonstrated that minute doses of hemolytic serum injected intravenously in anemic persons stimulated the production of erythrocytes and hemoglobin. Based on this fact, Metchnikoff suggested the theory that hemolytic toxin originating in the spleen was absorbed into the circulation in quantities insufficient to cause hemolysis but sufficient to stimulate erythroblastic tissue and result in polycythemia. Metchnikoff's well publicized theory displaced Osler's and Turk's theory of primary hyperplasia of erythroblastic bone marrow and was generally accepted. Gertrude Johnson,²⁷ in 1925, was the first to disagree with the Metchnikoff theory when she suggested a relation between endocrine deficiency

and polycythemia vera. No evidence in favor of this theory was presented except the presence of ovarian deficiency in the 2 patients observed by her.

In an examination of the bone marrow of polycythemic patients Reznikoff and his co-workers²⁸ in 1935 observed distinct capillary thickening, "probably fibrosis," and subintimal and adventitial fibrosis of subarteriolar capillaries, arterioles, and arteries. These vascular changes, especially in the capillaries, suggested to them the possibility that such lesions might lead to anoxia of the bone marrow with compensatory or overcompensatory polycythemia.

Wilbur and Ochsner,²⁹ in 1935, reviewed the development of the theory that, since polycythemia is frequently associated with peptic ulcer, the cause of polycythemia was hypersecretion of Brunner's glands in a mechanism just the reverse of pernicious anemia. They concluded that the association between polycythemia and peptic ulcer is not frequent enough to establish a distinct relationship. Tinney, Hall and Giffin³⁰ were unable to find any conclusive evidence of a causal relationship between polycythemia and peptic ulcer. Stenstrom and his associates³¹ were unable to produce relief of polycythemia by roentgen irradiation of the region of the pylorus.

Petresco³² suggested that there is an etiologic relation between polycythemia and disorders of the diencephalon. This theory, however, has not been generally supported, and most authorities agree that the theory of local anoxia of the bone marrow is the most acceptable. The relationship between polycythemia and myelogenous leukemia, however, is not adequately explained, although in both conditions there is a reversion of the bone marrow to a fetal type of erythroblastic activity with complete replacement of the yellow marrow by red. Minot and Buckman³³ explained the variations in the late blood picture by two different mechanisms. The typical fluctuations in the level of the erythrocytes, they feel, depend on variations in the

balance between the increased blood formation and a hypothetical increased blood destruction. The other changes in the blood picture they explain on the theory that the myeloid tissue undergoes a disorderly proliferation and loses its ability to produce cells in proportion to the demand for them.

In recent years there have been several interesting attempts to duplicate polycythemia experimentally. Numerous investigators have induced polycythemia by the administration of cobalt chloride, but no one has demonstrated cobalt as the causative factor of Vaquez's disease. Davis, first in dogs,³⁴ and later in humans,³⁵ showed that the erythrocyte count was markedly increased by amphetamine sulfate when administered daily. He theorized that the drug may increase hematopoiesis by causing local hypoxia of the bone marrow through diminution of the blood supply to that tissue. His work has been confirmed by Simon,³⁶ who warned that true polycythemia might result from prolonged administration of amphetamine.

COMMENT

The patient reported is of interest because the condition appeared when he was so young. From the history it seems that the disease must have been well developed at the age of 22. He is of further interest because at his first admission to the hospital his acute infection had probably depressed the erythrocyte level to normal, but neither the infection nor the large doses of sulfonamides depressed his hemoglobin below 90 per cent. The assumption seems justified that attempts to control the disease by the administration of hemolytic drugs cannot be successful unless hemolysis to a dangerous extent is induced.

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CLINICO-PATHOLOGIC CONFERENCE*

THE DEPARTMENT OF MEDICINE, GALLINGER MUNICIPAL HOSPITAL

RETICULUM-CELL SARCOMA CAUSING CHOLEDOCHODUODENAL FISTULA AND LIVER ABSCESS

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November 2, 1944

DR. YATER: Dr. Stiernberg, intern on ward L, will present the next case.

DR. R. CAM STIERNBURG: The patient, a male negro aged 62 years, was admitted on October 27, 1944, complaining of weakness, fatigue and abdominal distress. He had been in good health until a year before, when he began having intermittent attacks of "gas formation" with belching and nausea occurring after eating and relieved by the use of sodium bicarbonate. He had been constipated for 4 months and had lost about 14 pounds in 2 months. He had had a "misery" in his abdomen for about 2 months associated with nausea. For a month he had subsisted on chocolate, milk and oatmeal. He was able to "carry on" until 3 weeks before admission, when he was told by his friends that his eyes were yellow, and he noticed that his urine was much darker than it had been. A week later he stopped working because of weakness. He had had a penile lesion in 1916, and had received 20 to 25 injections in the buttocks in 1939. The past history and family history were noncontributory.

On admission the temperature was 98.6°F., the pulse rate 76 per minute, the respiratory rate 20 per minute, and the blood pressure 110/65. He was well developed, moderately well nourished, and in no apparent distress. The sclerae were moderately icteric, the breath foul, and the teeth carious; the tonsils were cryptic and contained a white material. The heart and lungs were apparently normal. There was epigastric tenderness and a suggestion of some shifting dullness in the flanks. The genitalia, prostate, rectum and extremities were apparently normal.

The urine was normal except for 4 plus bile and a large amount of urobilinogen. The hemoglobin was 68 per cent, the red blood cells numbered 3,190,000 per cu. mm. of blood, and the white blood cells 12,900, with a normal differential count. The van den Bergh test gave a prompt direct reaction with 10 mg. of bilirubin, and the icterus index was 71. The blood proteins measured 5.67 grams per cent, with 3.4 grams of albumin and 2.27 grams of globulin. The cephalin flocculation test was negative after 48 hours, and the prothrombin time was 100 per cent normal. The Kahn test of the blood was 1 plus. The stools were positive to the guaiac test on several occasions. The amount of bile and urobilinogen in the urine varied a great deal from time to time, from much to little. A galactose tolerance test on admission

* These conferences are held under the Chairmanship of the Head of the Department of Medicine, Dr. Wallace M. Yater, every Thursday from 2 to 4 p.m. Cases of particular interest, or those presenting diagnostic problems, are presented and discussed. This is a résumé of the discussion of such a case.

gave a return in the urine in 5 hours of 2.39 grams. The blood cholesterol on admission was 222 mg. per cent, with the cholesterol esters measuring 163 mg. The leukocyte counts were 12,800, 20,100, 6,800, 6,500, 13,400, 12,250, 21,150, 8,300 and 10,300, with the differential count remaining normal except for an increase in band forms to 27 per cent.

Under observation the patient developed frequent chills and a very irregular fever, which rarely exceeded 103°F. His appetite improved, however. An abdominal paracentesis performed on November 2 was unproductive. A roentgenographic examination on November 9 was negative, but a serial gastrointestinal X-ray examination begun on November 15 showed a deformed duodenal cap, irregular filling and a mottled appearance of the descending limb of the duodenum, and a suggestion of a fistulous tract between the duodenum and the gall bladder (fig. 1). There was a 15 per cent gastric residue after 6 hours and some barium remained in the duodenum. A roentgenogram of the chest was negative.

DR. YATER: This is your patient, Dr. Moser. Do you care to comment?

DR. JAMES M. MOSER, JR.: The history of pain and the negative cephalin flocculation test lead me to think that the patient has obstruction of his common bile duct. However, the various features are confusing, and I am at a loss to suggest what the cause of the obstruction may be.

DR. YATER: Dr. Keliher is the visiting physician in charge of the patient, and we should like to hear from him.

DR. THOMAS F. KELIHER: The history is not suggestive of biliary colic. To me the character of the pain and other features indicate a progressive lesion such as a neoplasm. However, the chills and fever point to an infection. Could we have a cholangitis complicating chronic obstruction of the common bile duct from a neoplasm?

DR. YATER: Your idea is appealing. The

chills and fever with jaundice and leukocytosis are very suggestive of suppurative cholangitis. This usually results from obstruction of the common bile duct by a stone. However, as you say, the general picture is more that of carcinoma. Nevertheless, this X-ray film shows evidence of a fistula between the duodenum and the biliary tract. That is usually caused by a stone eroding through from the gall bladder or common bile duct and passing down the duodenum, in which case the jaundice is relieved and the cholangitis may subside. The moth-eaten appearance of the duodenum, which Dr. Reed states may be caused by carcinoma of the

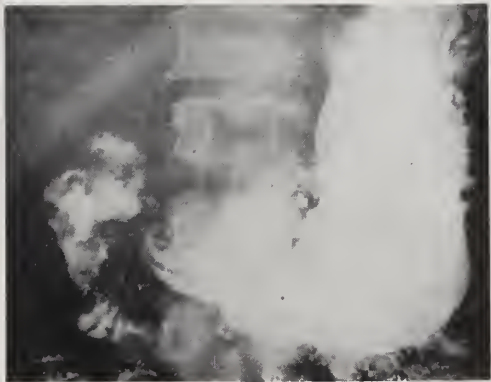


FIG. 1. Barium meal showing "moth-eaten" appearance of duodenum and suggestion of fistula.

duodenum, could also be the result of periduodenal adhesions. I suggest that we ask Dr. Reed to repeat the barium meal and follow its course at intervals of a half hour in order to see just where the barium goes from the duodenum. Dr. Katz, what do you think the various tests indicate?

DR. SOL KATZ, *Assistant Medical Officer*: They aid us in differentiating between the causes of jaundice due to liver disease and those due to obstruction. The negative cephalin flocculation test eliminates an active diffuse hepatocellular process. Normal values for blood cholesterol and cholesterol esters usually indicate that the liver as a whole is working efficiently, as do the negative galactose tolerance test and the normal

prothrombin time. The presence of urobilinogen in the urine shows that if there is obstruction of the ducts it is not complete. The serum albumin and globulin are present in about their normal relationship, a finding which is opposed to the existence of advanced diffuse liver disease. These data indicate most likely partial obstruction of the common bile duct, commonly due to stone.



FIG. 2. Barium meal one hour after ingestion showing barium having passed through fistula into intrahepatic biliary system.

November 30, 1944

DR. YATER: I shall ask Dr. Moser to tell us what has happened in the case of the negro who had jaundice with chills and fever.

DR. MOSER: The repeated gastrointestinal X-ray examination done with films made every half hour showed a definite fistulous communication between the duodenum and the biliary tract. The barium actually filled the main portion of the biliary ducts within the liver after an hour (fig. 2). The icterus index has dropped to 35. The cephalin flocculation test was negative again on November 6, but yesterday it was 3 plus. The erythrocyte count on November 25 revealed that a hyperchromic, macrocytic anemia of 1,730,000 cells had developed, with a color index of 1.6.

DR. YATER: Dr. Keliher, have you any further impressions?

DR. KELIHER: Our impression at first was that the patient had an impacted stone in the common bile duct. I am still confused, since

the clinical manifestations are those of infection. Nevertheless, I think that a malignant neoplasm cannot be ruled out.

DR. YATER: Suppurative cholangitis still remains a possibility. The cause is questionable. Is it a stone or a neoplasm? There are two courses to pursue. One is to try to get medication into the bile ducts by the same route as the barium takes, possibly by the use of a sulfonamide; or penicillin could be tried parenterally. Do you think operation is advisable?

DR. KELIHER: He needs more "building up."

DR. YATER: It is difficult to imagine what surgery could accomplish. There is a fistula already present through which bile can escape, and the icterus index is dropping. At least we could get a better idea of the lesions that exist, and perhaps better drainage could be established. On the other hand, because of the poor condition of the patient, surgery might be the death knell of the patient.

December 21, 1944

DR. YATER: I understand the man with the choledochoduodenal fistula was operated on last week.

DR. MOSER: Yes. The patient continued to have chills almost every day, his temperature course remaining very irregular. However, the icterus index had decreased to 9 on December 12. The use of penicillin was discussed but never carried out. The operation was performed on December 14. The surgeon thought he was dealing with an inflammatory condition. There were many adhesions in the region of the duodenum and the common bile duct, which was dilated and thought to be obstructed. The pancreas was said to be enlarged, but the gall bladder was not involved in the adhesions although it appeared to be chronically inflamed, without stones. The common bile duct was drained. The patient seemed to be improved for 4 days but died on the fifth.

(Continued on page 139)

President's Page

A PARTING WORD

By the time these lines are published, I will have been overseas for several weeks. As I told the membership at a meeting held on February 14—and, incidentally, this was the only scientific meeting at which I had been able to be present this year—I have found the experience of being President a highly interesting one despite the handicaps under which I served. It has been a privilege which comes to comparatively few physicians and I am deeply grateful for the honor conferred upon me.

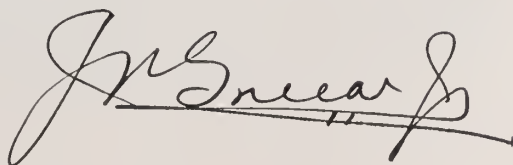
There are a few things I would like to say in my last message to you as President. Although I have not been present at Society meetings, I have attended sessions of the Executive Board regularly and I am certain that because of this I have a better understanding of the problems which confront the medical profession.

I am deeply concerned lest the medical profession fails to take advantage of its opportunities for leadership in the health field. For changes in medical practice are inevitable; let there be no mistake about that. These times call, therefore, for strength, courage and vision. Without these qualities we may well fail to measure up to what is expected of us.

Now, I understand that there are some physicians in Washington who are not enthusiastic about plans being considered by our Committee on Medical Care for wider and more equitable distribution of medical service. In fact, they are opposed to planning of any sort. I have no illusions about plans. I know that none of them are perfect and that from time to time they all need strengthening and improvement. But I say to our members in all sincerity, do not fail to get behind the plans proposed by your Committee. I feel certain that those which it submits will provide a sound foundation on which to build. If you can offer suggestions to improve them, by all means do so, but a negative attitude in these times cannot be justified.

In closing, I want to say something about the men in the armed forces who will some day come home. They are looking to you to protect their interests, to be forward-looking and to solve the problems before you to the best of your ability. The service physicians to whom I have spoken are sure that changes are in the offing. Their real concern is that physicians on the home front will refuse to recognize this fact and when they return it will be too late.

I have nothing further to add except that I wish all my friends the best of good fortune. It is my sincerest hope that our Society, which has been so liberal in its outlook during the last several years, will go on to greater things and that upon my return I will find it has outstanding accomplishments to its credit.

A handwritten signature in dark ink, appearing to read "J. B. Sneed". The signature is fluid and cursive, with a long horizontal stroke extending to the right at the end.

Editorials

CANCER CONTROL

Since 1938, the month of April has been set aside by Presidential proclamation as Cancer Control Month. The annual observance serves as a time for taking inventory. What has been achieved? What are we doing now? What needs to be done?

To the busy practitioner every month is cancer control month. He knows or should know that he is the first line of defense against this much dreaded malady. He sees the patient first and therefore his advice and its reception largely determine the outcome of the case. In all its aspects, diagnosis and treatment, prevention and research, lay and professional education, cancer is one of our most important public health problems. Nevertheless, it is not communicable and in the last analysis each case becomes a strictly personal problem. It is safe to say that in no other professional situation is the confidential doctor-patient relationship of greater value. Of prime importance, therefore, is the provision of facilities for postgraduate training in order to increase the skill of the practitioner in early detection; to make him "cancer conscious"; to make him realize the necessity for a careful physical examination; and to teach him where to send his patient for expert diagnoses and treatment whenever the occasion calls for it.

The basic principles in the treatment of cancer have changed little since the days when the ancient physician burned it out with a hot iron. Surgery and radiation are designed merely to remove or destroy the cancer tissue. According to Dr. Ludvig Hektoen, the aphorism of Celsus, the great Roman writer, physician and contemporary of Christ, that "only the beginning of cancer admits of a cure" is the most impor-

tant generalization ever made about cancer. Even today, when a cancer is treated is more important than how it is treated, provided, of course, the patient is in competent hands.

While we have improved and refined our techniques of cancer-cell destruction, little or no progress has been made in chemotherapy. No chemical or antibiotic has yet been found which will selectively destroy all cancer cells and not affect, at the same time, normal tissue. On the other hand, the problem is by no means hopeless, and interesting leads in this field are now being followed at the National Cancer Institute, Bethesda, Maryland, and elsewhere.

Regarding the etiology or causation of cancer, definite progress can be reported. We now know that cancer is not due to a single cause as are infantile paralysis, whooping cough, scarlet fever and other communicable diseases. Over 100 different chemical compounds have been shown to induce cancers in animals, exclusive of the energy agents (X-rays, gamma rays of radium, ultraviolet rays in the sunlight and heat). Cancers can now be induced therefore at will in many experimental animals by employing various external environmental agents and substances. More recently cancers have been induced also by artificial disturbance of the normal hormonal balance of the animal, and normal cells cultivated in vitro have been transformed into cells which would induce cancers (100 per cent takes) within 10 days when implanted again into the same family of mice from which they were originally obtained. Moreover, it is fairly well agreed among all cancer investigators that the conditions, internal and

external, which are responsible for the genesis of cancer of one organ or tissue may not be closely related to the conditions which bring about cancer of another organ or tissue. For example, it seems clear that the genesis of cancer of the female breast bears no relation to the genesis of cancer of the skin or of the male prostate, and for this reason the attack on cancer must be made site by site.

In the light of all these observations, it is misleading and inaccurate to say that we do not know the cause of cancer. What we do not yet know is the nature of the intracellular transformation which takes place when normal cells cease to function harmoniously, assume unlimited growth and become parasitic.

R. R. SPENCER, M.D.

Chief, National Cancer Institute

ALCOHOLISM

In one of those strange turns of social psychology whereby the obvious is suddenly rediscovered, a large segment of the population of the District has recently become aware of the futility of the present methods of dealing with the ever-present problem of alcoholism.

Alcohol has been used to excess by some persons ever since its qualities as a beverage were discovered, and of recent years at least the number of alcoholics has been recognized to be large, although reliable figures are not available. Until very recent times an attempt has been made to deal with alcoholic overindulgence as a moral problem; drunkenness, at least in public, is a misdemeanor, and the courts may and do impose sentences on the legal theory, presumably, that no one drinks unless he wishes to—whereas, as many know, there are numerous “compulsion drinkers.”

The records of the police courts the country over are strewn with instances in which one man (or far less frequently, one woman) has been sentenced to jail for a few days twenty or thirty times or more, often in rapid succession! If patients suffering from an infectious disease relapsed as frequently, a large scale research would long since have been instituted to learn better methods of treatment, yet the judicial merry-go-round continues.

In the problem of alcoholism one must consider social pressures, economic and family situations, the ease of securing alcohol, and a multitude of

other factors; the main question, however, is why the various factors act as they do upon the individual. He may drink on account of a persistent low blood sugar, or because of insomnia, or to mask various physical symptoms; in many instances emotional tension is the situation from which relief is sought. Primarily the problem of alcoholism is a medical one, and certainly one in which the physician, whether general practitioner, internist or psychiatrist, should display a serious interest. Fortunately, more and more of the medical profession recognize this fact, and the same is true of the general public.

A fair proportion of alcoholics, at least, desire to be cured. They are entitled to expect that the community will provide the needed facilities, just as it now provides that next-to-useless treatment facility, the jail. That is reasonable, for the benefit of community and patient alike. The need of mental hygiene clinics has been officially recognized in the District, and it is to be hoped that suitable personnel can be located soon. One proper function of such a clinic is the treatment of suitable cases of alcoholism. The courts now have the needed authority to use the mechanism of probation, and could insist on the use of the clinic by probationers who offered reasonable prospect of improvement. Patients under the care of the clinic could be referred, after proper physical (including psychiatric) examination, to auxiliary social agencies, some of which render invaluable service in such cases.

For those who seem unlikely to respond to ambulatory treatment, facilities should be provided for prolonged care under compulsion, just as is now the case with the mentally ill. At present, Gallinger Hospital provides emergency care for acute alcoholism, and those patients with mental disease due to alcohol or associated with its excessive use can be committed as "insane." Provision for the commitment, as criminals, of non-psychotic inebriates, preferably for an indeterminate period and certainly not for the traditional ten days, seems to be called for.

Such commitment should preferably be made to a specialized institution or to a separate portion of some existing plant. The Medical Society has long since indicated an interest in a specialized institution of this sort; certainly the time is now ripe for the medical profession of the District to lead the way in directing public interest toward a more intelligent and effective manner of dealing with this medicosocial problem than is possible by using the jail as a place of treatment.

W. O.

THE NURSING SITUATION

Nothing in recent months has stirred the emotions of our people more than the report that units of our military forces have gone overseas without nurses. In their alarm over this situation they have demanded prompt action. Army and Public Health officials have been insistent that legislation providing for the drafting of nurses be enacted immediately. Others in high places are not so sure this is the solution.

Whether or not a draft law is necessary is therefore still a debatable question. Many observers will agree with the *Washington Evening Star* which on February 7 editorialized as follows:

"The slightest possibility of neglect of our wounded soldiers brought from the battlefields to hospitals in this land of plenty should provide all the impetus necessary behind the bill to draft trained nurses."

"The hearings in congressional committees and the opportunity for debate in both houses of Congress are necessary parts in the perfection of adequate legislation. But there can be no delay. There can be no compromise with a need so overwhelming in its implications. That we, of all people, should invite criticism from the wounded that we have been too late, with too little, in responding to the appeal of their suffering is a thought that should shame us to speed and more speed in doing what must be done."

Hanson W. Baldwin, writing in the *New York Times* for January 31, takes the position

that "The plan for the drafting of nurses seems to this correspondent discriminatory and possibly—if all the reforms that could be made within the services are made—unnecessary.

"The nurse problem is only a part of the larger problem of the nation's manpower. That problem, too, can be eased, though probably not solved, by increased efficiency within the services. Some of the replacement training centers, posts or depots, especially a few abroad, are particularly inefficient and wasteful both of nurses and soldiers. Investigation and reform within the services must accompany manpower legislation by Congress."

Dr. Thomas Parran, Surgeon General of the United States Public Health Service, however, is an advocate of the draft for nurses. Testifying before a Congressional committee, Dr. Parran said:

"Should the Army be forced to recruit its quota indiscriminately, irreparable damage will be done to the entire nursing service structure, to the civilian front, and sooner than you think, to the military as well.

"It is for these reasons that I recommend the Selective Service principle for professional nurses to include civilian as well as military needs. This is total war. We must mobilize fully to guard against collapse on any front, military or civilian."

The Procurement and Assignment Service for Physicians, Dentists, Veterinaries, Sanitary Engineers and Nurses believes that if there is no other way to obtain nurses that are actually

necessary to the military forces, then the legislation adopted should provide a mechanism for adequate selection so that civilian health and safety will be protected.

The nurses themselves have been divided as to the course which should be pursued.

Regardless of differences of opinion, the cold fact is that nurses are not where they are needed on the fighting fronts. Whatever measures are taken to supply the 16,000 additional nurses which the Army insists it needs and the 4,000 additional nurses required by the Navy, they must be obtained now if our boys are to receive the attention they should have. And it doesn't make any difference whether the method adopted is voluntary or compulsory, just so there are results. And here it should be observed that the draft law if enacted could not be made operative for two or three months at least. In the meantime, vigorous recruiting must be relied upon.

There is, of course, always the danger of losing one's perspective in a crisis such as that which exists in the nursing field. In an effort to obtain nurses for the armed forces, discrimination should be used. As the Procurement and Assignment Service implies, consideration must be given to civilian needs and the essentiality of

the positions held by the nurses in the community. For example, key nurses in the hospitals or hospital schools should not be withdrawn until all other sources have been tapped.

The Procurement and Assignment Service for Nurses has not done as good a job as might have been done. The primary reason, of course, has been its lack of authority due to the fact that it has not been backed up by a draft law. Aside from this, however, there could have been better planning and organization at the top.

But again, let us return to the stark fact—we must solve this problem immediately. On the day this is written, the House Military Affairs Committee approved a bill for the drafting of registered or graduate nurses from 20 to 45 years of age for the armed forces. The bill prohibits draft boards from inducting eligible civilian nurses until all qualified graduates of the United States Cadet Nurse Corps in each community have been taken. Essentiality of civilian nurses to a community will be determined by the Procurement and Assignment Service of the War Manpower Commission. Nurses may continue to volunteer for service with the Army and Navy and be commissioned. What happens to this legislation remains to be seen.

In and Out of Focus

BY THE OBSERVER

Medicine and the Changing Order One of the most comprehensive investigations of medical care and the probable effect social changes will have on the practice of medicine is being conducted by the Committee on Medicine and the Changing Order of the New York Academy of Medicine. The Committee, which began functioning February 25, 1943, recently issued an interim report which your Observer found highly enlightening.

The objectives of the Committee as stated in

this report are "...to be informed on the nature, quality, and direction of the economic and social changes that are taking place now and that are clearly forecast for the immediate future; to define in particular how these changes are likely to affect medicine in its various aspects; to determine how the best elements in the science of medicine and in its services to the public may be preserved and embodied in whatever social order may develop, so that ultimately the best possible medical care may be made available to

the largest number of persons at the most economical costs."

In pursuing its study the Committee has held weekly conferences to which they have invited speakers to address them on some subject which is in line with the Committee's objectives. According to the Committee, "every shade of opinion and every important school of thought was represented." Among those who addressed the Committee were economists, sociologists, historians, publicists, bankers, industrialists and labor representatives. The Committee also invited experts to prepare monographs on major current sociomedical problems.

The Committee concludes:

"It is obvious that medicine cannot, save with great harm to all, govern its progress by considerations of profit and loss, nor can it compromise with quality. It is equally obvious that, because there is a widespread demand for good medical care for all at the lowest possible costs, medicine cannot continue to operate as it has done in the past. Precisely because of the evolution medicine has experienced, and precisely because it now has so much to offer, there is widespread demand for good medical care. This demand carries with it a number of basic problems which medicine, in coöperation with other social groups, must define and somehow solve.

"The real problems are many and they cannot be simplified by thinking solely in terms of the costs of medical care. If the quality of medical care is to be improved, it should be clear to all that medical education and research must be recognized as among the basic problems to be studied, and it is necessary that laymen as well as physicians must understand what the term medical education connotes. . . ."

"The quality of medical practice and of service is . . . largely dependent on public understanding and demand. The people need to know how certain diseases may be prevented, when medical treatment is required, what resources in prevention, diagnosis and treatment are available, and what in substance constitutes good medical care. The public needs also to understand the uses and values of convalescent care and of rehabilitation after the acute phase of illness is passed. The full advantages of modern medical science cannot be gained without the intelligent and informed coöperation of the public.

"Among the major problems that need to be solved are those affecting the hospital. This institution, which not so long ago was little more than a pest house, now is one of the important agencies in the medical realm. The

hospital is primarily a place where the sick are housed and treated, but it is also an educational institution where the medical student and the physician learn practical medicine. It is, in addition, a research organization from which many of the new developments in clinical medicine emanate and where, in the last analysis, most of them must stand trial. These functions of the hospital are related to one another, and as any one of them is neglected or restricted, so are the others likely to lose in quality and effectiveness, to the detriment of the sick individual and of medicine."

"Many of the confused and paradoxical relationships between the private practitioner and the corporate bodies providing some form or other of medical care and treatment are of such a grievous nature that they urgently demand correction. The out-patient departments of hospitals in which physicians serve without compensation; the free clinics, health centers, diagnostic and treatment clinics of the Health Departments; the industrial health services; the school health services; all those require careful scrutiny to the end that they may be more effectively related to the work of the individual practitioner of medicine, upon whom, in the last analysis, devolves the major responsibility for the care of the sick."

"How to make preventive medicine socially effective is perhaps the greatest problem of all. Certainly it is the most complicated, for it involves not only the whole medical realm but the public as well.

"One of the practical, urgent, and multipartite problems that confront us today may be described as the economics of medicine. This involves not merely what the patient is required to pay for medical care, but all the economic aspects of medicine, including those of medical education, medical diagnosis and treatment, hospitalization, and medical research. Actually, however, these so-called economic problems are not independent of the others. They are in fact elements of the larger problems of education, practice, hospitalization, and so forth. They are not truly resolvable independently. Yet much particular study and experimentation will be required in their solution."

"... In the long run real economy in medical care derives from the quality and competence of the treatment given, rather than from the expenditures in a given illness. It is, therefore, not only feasible but most likely that in treating illness more competently and more effectively the ultimate per capita expenditures on medical care during specific time periods may be appreciably reduced, even though the costs of treatment may be higher. A reduction in the costs of medical care need not, therefore, inevitably be realized in terms of lower fees, but rather in terms of fewer sickness expenditures because of a lowered incidence in illness."

"The current inclination to manipulate society accord-

ing to some preconceived plan and the efforts to cure the world of its ills by 'massive' doses of social legislation are fraught with great dangers. The greatest among them is that the laudable ends will be betrayed by the incompetent means employed to gain them.

"... It should be obvious that actual experiments in various formulas for medical care are essential before effective legislation is made possible."

"... Pending final evaluation of these matters, we are convinced that actual experiments in various formulas for medical care should be undertaken before legislation is attempted."



**Education—
Its Purpose** There have been many differences of opinion as to the objectives of education, and not a little criticism of the present system. Dr. Norman L. Hoerr, Professor of Anatomy at the Western Reserve School of Medicine, writing in the *Bulletin of the Academy of Medicine of Cleveland* for January, is one of the critics of the modern educational methods. He says that in reading literature on education, one is impressed by the fact that almost all articles dealing with the subject fall into two groups, those dealing with the content and those dealing with methods of presentation.

"The former," he says, "argue about the superior value of the scientific subjects over the humanities, or vice versa, about the value of foreign languages, about sufficient time for chemistry or for psychiatry, about the necessity for the student to survey, however superficially, all the realms of knowledge, about the great need for courses on making friends and getting along with people.

"Articles of the second class discuss interminably the mechanical minutiae, methods of visual education, how languages can be taught in eight weeks instead of three years, whether a discipline should be divided into its component parts vertically or horizontally, whether a subject should be taught by the case history method, or only general principles be stressed, how much detail should be required, whether certain sequences of courses are vital, or prerequisites be abolished, whether examinations should be of the objective or of the essay type, what grading system should be used, the advantages of the semester plan over the quarter plan, how, in short, the student can best be trained."

Dr. Hoerr protests that this literature misses the mark—

"The breath of life is not in them; we are cast down into the valley of bones, and the prophet Ezekiel complained long ago, 'Oh Lord! these bones are very dry.' That the teacher may be human is overlooked; that the student may be human is disregarded."

He then asks the question, "What, then, is the chief purpose of education?" He says this "may be answered quite simply, but is evaded time and again. Let us suppose that you wish to equip your son for a journey to a far country, and that for the most of the trip he will be on foot and on his own. You may follow either of two courses: you may load him down with provisions enough for the entire journey; or you may give him a gun, fishing tackle, matches and skillet, and teach him how to live off the country through which he passes. Which course is to be preferred?

"Well, perhaps you have had a hard struggle to get some provisions together for yourself, and you decide that you will make things easier for the lad. He will not have to forage, and occasionally go hungry; you are going to save him some heart-aches if you can. If, you reason to yourself, he has enough provender to last the trip, he will be more comfortable, and better nourished, he will not have to waste time hunting and fishing and cooking, and he will make better time. But will he?"

"It is a much harder job to teach the young to shoot, than to dish out the cooked food. It requires more personal supervision, more interest in the problems of the individual student, more salesmanship on the part of the instructor. To convince the student of the value of learning to hunt and fish, the instructor must set the example, be constantly learning the newest thing in pump guns or trout flies, in fact he should be designing improvements himself. Students are so often startled to learn that we are students too, a little more expert shots, perhaps, and a little farther along on the trail, but still absorbing woods-lore by exploring new fields and streams. How shocked some of my carefully nurtured students are when I tell them that in 'possum hunting, I, too, am completely in the dark!"

"Clifton Fadiman, in 'Reading I've Liked,' tells why he considered John Erskine one of the greatest of his teachers. One thing which may help to explain the influence Erskine wielded over his students, Fadiman says, 'was his enormous respect (not merely liking) for his subject matter. This may seem a common-place, but it is not. Many teachers—no more surprisingly than other frustrated human beings—have a silent, gnawing contempt for what they teach. Unaware of this contempt, they often find it subtly translated into a resentment of

their students. The result is vitiated teaching, teaching of a purely formal sort.'

"When we criticize students, or teachers or doctors, we usually exercise the common human failing, refusal to realize that perhaps the fault lies with us. What are we doing wrong as students, where is our error as doctors and teachers?"

"Perhaps the answer lies not only in our lack of regard for the true objectives of education, but also in our methods. What are the chief processes of learning? Educational processes (here I borrow freely from Alan Gregg) may be grouped under three main headings: observation, learning to see and describe what one sees; reasoning, learning to make correct deductions from one's observations; and reading, learning what others have observed and inferred."

Your Observer would be the last to quarrel with Dr. Hoerr's conclusions.



In an address before the *"If We Are to Avoid. . . College of Virginia at Richmond Socialized Medicine"* last September, Governor J. Melville Broughton, Governor of North Carolina, unburdened himself of his views on medicine. Preliminary to a statement of his position he made it clear that he was well aware that what he called "reactionaries" and "conservatives" were "appalled at the spread of corporate and governmental activities in respect to the practice of medicine and are girding their loins for a last ditch fight against this invasion of one of the oldest and noblest of the professions."

"The medical student of tomorrow and indeed of today cannot become qualified wholly in the laboratory, the classroom and the clinic. His profession will inevitably be involved in new social trends and he must in the highest degree be intelligently informed and responsive to these new conditions."

"Whatever may be our feelings with respect to the encroachment of the federal government upon the field of medicine, it is an inescapable fact that our government is already a tremendous factor in this field and will be increasingly so in the coming years. In fact, much of this enormous expansion of governmental activity in this direction is inevitable and unobjectionable. For example, the federal government is now operating by far the

largest hospital system in world history. This result was approaching even after the last World War, and the results of this present epochal war will extend this system beyond the range of the imagination."

"In the aggregate, the amount of medical practice already directly carried on by the federal government or under its supervision, if not control, far exceeds the estimate of those who have not made a careful study of this development. In brief, these activities are not something merely to be anticipated or looked forward to with apprehension. They are here; and in enormous proportions. Moreover, the results of these activities while not wholly free from criticism, are satisfying an increasingly large number of our citizens and raising in the minds of millions of others the question as to whether this sort of supervision, control and support of medical activities should not be extended.

"This is not a recent phenomenon, although it may be conceded that in the era of the New Deal these trends have been greatly accelerated. Those who would label these developments merely as New Deal manifestations of passing importance are lacking in a sense of proportion and perspective. With no thought of indulging in political discussion, it is sufficient to note that even in conservative Old England there is a growing sentiment for a broadly social system of medical practice and hospital care . . ."

"Therefore those who are opposed to socialized medicine and all its works must look further than to contemporaneous or recent political developments. They must ponder the fact that all over this earth, including conservative England and our less conservative America, there is a deep-seated and growing human urge and insistence for a program of welfare, security and health available to all people, regardless of financial circumstances."

Governor Broughton says that there are great opportunities for leadership open to the medical profession.

"... if we are to avoid what many consider the evil consequences of socialized medicine under federal sponsorship and control, with fantastic cost and unlimited political manipulation, it is quite apparent that the individual states, cities, communities and counties must be willing to assume their responsibility and plan more progressive programs. Without seeking even to suggest the scope or details of such plan, it may be stated that the ultimate purpose of such a program should be that no person in any state or community should lack adequate hospital care or medical treatment by reason of remoteness, poverty or low income. Nothing short of a program so comprehensive will satisfy the growing social consciousness of our people, and the failure to recognize these deep-seated

human emotions and desires will be but an invitation for federally socialized medicine in some of its worst aspects."



*California's
Health
Service Bill*

We have become accustomed to sensational news from California for that state seems to thrive on the spectacular. Late

in January a compulsory health insurance bill was introduced in the State Legislature. That was not so surprising considering the agitation for social reform which has been going on in California for a number of years. What did jolt the medical profession was its joint sponsorship by Republicans and Democrats, leadership being given by Governor Earl Warren, who made such a favorable impression upon the Republican National Convention last June.

Under the provisions of the bill individuals would be entitled to services "rendered by a physician and surgeon licensed in California whenever such services are required by the standards of good medical practice for preventive, diagnostic, or therapeutic or other medical treatment or care. These general services may be performed at the physician's office, or in a hospital or clinic, or anywhere else in California in accordance with the standard of medical practice in the community in which the service is rendered."

In addition the bill provides for consultation, specialist, laboratory and X-ray services. Necessary hospitalization, excluding ambulance service, for not more than 21 days a year for each separate and distinct illness or injury, is included, as are drugs, medicines, bandages, splints and other supplies prescribed by the attending physician. Limited dental services are also to be furnished.

This scheme is to be financed by employers and employees each contributing $1\frac{1}{2}$ per cent on salaries up to \$4,000. Free choice of doctors is provided for under a fixed fee system.

As was to be expected, the California Medical Association was not long in interesting itself in the Governor's health program. Early in

December, 1944 Governor Warren conferred with councilors and officers of the Association, stating that he favored and would urge the establishment by law of a system for the distribution of the costs of medical care, to be financed if possible through new and additional payroll taxes. The Governor said, however, that he had an open mind as to the details of any such system, and requested the Association to submit the kind of a medical care plan it would approve. According to a statement issued by the Association, "officers and members of the Association have held informal conferences with representatives of organized labor and a representative of the California Farm Bureau. Representatives of labor and a representative of the Farm Bureau have appeared before the Council and before the delegates at this special meeting of the House of Delegates. The Governor of the State of California has asked of us a question. We must now proceed to answer it."

The Association adopted a resolution in which it said it "cannot endorse any system of compulsory health insurance which has thus far come to its attention"; however, that it "is equally convinced that there is an existing problem with respect to the distribution of the costs of health services and therefore its position with respect to such problems must continue to be a positive and progressive one."

One of the solutions offered by the Association was "an increase in the benefits of the California Unemployment Insurance Act, without increasing payroll taxes, to provide cash indemnities to wage earners when ill or injured through non-industrial causes."

It also went on record as being in favor of "the principle of distribution of the costs of medical care by means of prepayment, and its sincerity in this regard is evidenced by its expenditure of no inconsiderable money and effort for the development of California Physicians' Service and that . . . the . . . Service has been offering to the public a statewide, non-profit prepayment plan for the past five and a half years."

It resented the statement that the California Physicians' Service was a failure because "it covers only about 125,000 people," arguing that its membership was rapidly expanding.

It concluded its resolution with the plea that "recent proposals to establish some form of compulsory health insurance in this State have come at the last minute without any opportunity for adequate consideration and planning by any of the many interested groups or sufficient time for interchange of opinions and knowledge."

Latest reports would indicate that Governor Warren's legislation will receive serious consideration and that it may be enacted.



More about Service Physicians

If one is to judge by the comments in medical journals throughout the country, the medical profession on the home front is becoming acutely conscious of its obligations to service physicians. There are few medical societies, it appears, who are not considering ways in which they can assist these physicians upon their return to civilian life.

Your Observer has commented on local plans in previous issues. In this one he wishes to quote from a recent address by Dr. Alfred H. Jackvony, President of the Providence Medical Association. Dr. Jackvony said,

"We individually and as a group, must concern ourselves with the economic picture that faces the demobilized doctor. As I see it, this situation is a vital one, particularly as it affects the younger men who went directly to the Services from internships or residencies. Older doctors well-established in practice prior to their enlistment will need help to be sure, but I am confident that their experience and previous position in the community will materially lessen their difficulty in reestablishing private practice.

"But how are we to help the young doctor who answered the call to military duty straight from a limited hospital training, and who will return to us with one, two, three, four, or more years of service with the armed forces for which he has received fixed compensation? Consider, too, the problem facing most of these doctors who have won promotions providing higher incomes, and who have married and established homes during this time. How

can we best encourage him and help him to make the transition to competitive private practice without too great sacrifice for his immediate family?

"We maintain that the best form of medicine in this country is that of private practice. Will we now come forward with strong evidence of our belief so that these young doctors will follow the paths we have trod and not be deterred into regimented programs under non-medical auspices? Will we recognize the seriousness of the problem that faces organized medicine in this post-war period? I am of the firm belief that we will.

"The possible approaches to a solution of the problem are undoubtedly many. Certainly I do not feel qualified to present more than a few personal ones. I feel that doctors demobilized until now and probably those within the present year, will be readily absorbed into our communities with a minimum of difficulty. But for these men, and particularly for the larger group to follow them later, perhaps we may well explore the possibility of some system whereby older and more experienced doctors, individually or as a group, may take on these younger men as assistants, thus permitting them gradually to reestablish themselves educationally and economically.

"For other returning doctors the rigors of private practice will be eliminated because of disabilities incurred in the line of military duty. These men will merit our special attention. They should be trained and then given preference for established positions in hospital, public health, institutional, industrial and allied fields. These men will not want such positions as a form of recompense for service to their country, or as a charity grant, but I am sure that if they are allowed to specialize in such activities and to utilize fully their professional training they will welcome the opportunity."



Why Medical Bureau Is Successful

On December 2 MEDICAL BUREAU was four years of age. Despite the difficulties encountered in its establishment and operation, the BUREAU has been most successful. More than 300 physicians now subscribe to it. Thousands of Washingtonians turn to it for information about physicians or request that physicians be sent to them when they do not have one of their own.

As might be expected, one of the difficult problems with which the BUREAU has had to cope has been that of retaining competent personnel. In this respect its experience has

been similar to that of other telephone exchanges and, for that matter, nearly all other employers. More serious has been the acute shortage of operators who can be trained to supply information and to handle medical calls in an intelligent manner. In view of this situation, the Medical Bureau Committee thought it would have to be satisfied with less than the best service. To its pleasant surprise, the service has been much better than was thought possible under the circumstances. So by and large the BUREAU has functioned very well and apparently to the satisfaction of physicians who subscribe as indicated by the response to several canvasses that have been made since the BUREAU was established.

Mention should be made of the fact that much credit for the efficient operation of the BUREAU is due to faithful employees who have been with the BUREAU since its establishment or for a long enough period to become thoroughly acquainted with its operation. Mrs. Marion R. Mannix, Supervisor, who is in charge of the office, and Mrs. Elizabeth Lenderman, Chief Operator, are especially to be commended.

By far the most important factor contributing to the BUREAU's success has been the confidence shown in it by the medical profession. This is most essential for without it the BUREAU could not possibly succeed. That is the reason why the calls and, especially, inquiries are handled with the greatest of care. For there must never be any doubt in the minds of anyone as to the BUREAU's integrity because that is its most important asset.

Although the manner of handling inquiries received from the public about physicians has been described before in the MEDICAL ANNALS, your Observer has the feeling that it will not be wasted effort if it is done again. Where an inquirer requests the name of a medical practitioner he is asked if he has a family physician. If he has, it is suggested to him that he seek his physician's advice as to a consultant. Usually, however, the inquirer has no physician or wants

to make a change so three names are furnished him. Names of physicians in the specialties and in general practice are given in rotation, and a record is made each time this is done. All Society members appear on the list, the classification having been supervised by the Executive Board. As regards the emergency calls, these are transmitted to members of MEDICAL BUREAU volunteering to take them, for the reason that the BUREAU has complete information only about its subscribers. Incidentally, the fact should not be lost sight of that the list of physicians used by the BUREAU was not prepared particularly for the benefit of Society members, although it has worked out that way, but to provide the public with reliable information.

Confidence which MEDICAL BUREAU has enjoyed is, then, the keynote of its success. Those who are responsible for its conduct have given assurance that they and the agency entrusted to them will continue to merit it.



Too Many Organizations Much is heard these days about combat fatigue. *Menace* Physicians recognize it as the *Health* commonest cause of disability among men and women in the armed forces. They describe it, in their own terminology, as psychoneurosis. In some respects the extreme weariness which afflicts people on the home front is equally serious. Its causes and manifestations are varied. For example, there is what might be called "organization fatigue." This malady has had a most damaging effect on the health of many individuals.

Since Pearl Harbor the American people have worked themselves into hysteria over organizations. Groups have been organized on the slightest pretext. No one can quarrel with the objectives of most of these organizations. Many of them are worthy enough and their existence would be justified were it not for the duplication of effort. For example, there are any number of organizations whose chief concern is the welfare of veterans. One hesitates to object to the

multiplicity of such groups for fear of being misunderstood. But the fact is that there are too many of them—many more than are needed.

Overorganization has also occurred in the medical field. On occasion physicians protest bitterly against the demands being made upon them by the various societies of which they are members. Here in the Nation's Capital, if a physician belonged to all of the medical organizations he would attend meetings every day in the month. In addition he would be required to be present at sessions of medical staffs of hospitals and other institutions with which he is connected.

When it gets to a point where a physician is devoting all of his time to his profession or activities relating to it, it is time to call a halt. For it is no exaggeration to say that if he does not do so he is inviting disaster.

A score of Washington physicians have died in the past year. Some of them were casualties of the war. In several instances too much strain was placed upon them by their practices and the demands of numerous organizations and institutions with which they were affiliated.

What is the solution? Where their practices are concerned, physicians must realize that at best their years are not many and they must conserve their health, especially after middle age. If necessary they must relinquish patients to others. As to the demands made upon them by organizations, they should eliminate all except basic ones. The Medical Society of the District of Columbia is in the basic category.

If physicians confined their organizational activities in the medical field largely to the Society they would be relieved of many obligations which now weigh heavily on them. Incidentally, the Society would benefit immeasurably. Then, too, nearly every activity of the various medical groups to which physicians belong could be developed within the Society.

There is no magic formula for relieving demands made upon physicians by too many

organizations. It is a matter of using common sense. By reducing the number of organizations to which physicians belong there will be a corresponding reduction in the number of meetings which must be attended, thereby diminishing "organization fatigue."

★

*You Can't
Buy Salvation* Too many physicians appear to be under the delusion that they can buy "salvation."

They give generously to any group which they believe will protect their interests or which promises aggressive leadership in a cause in which they believe. Utopia, it seems, can be realized if only enough money is contributed.

Now, of course, these physicians are being taken in by "sales talk." Furthering one's interests or cause is not accomplished by dispensing dollars and cents alone. Church members who profess to be Christians but limit their religious activities to financial support of the church are an apt illustration of what is meant. No one can quarrel with those who give generously of their wealth to such a worthy institution, but Christianity is a way of life which cannot be bought; it must be lived. In other words, an individual must give of himself as well as of his wealth if he earnestly seeks salvation in a religious sense.

So it is in medicine. The belief that writing a check to any organization promising to safeguard the future of medicine will bring promised results is equally unrealistic. The truth is that a medical organization, if it is to have any influence at all, must, aside from adequate financial support, have the active interest of those who make up its membership. Money has no magic power except to give a few individuals an opportunity to display their abilities. In the long run the only effective group is the one in which each individual shares not only the cost of a program but the effort that goes into it. Unless both of these are contributed generously, little that is really worthwhile will be accomplished.

(Continued on page 140)

HOSPITAL STANDARDS FOR INFANT CARE

In a communication dated February 19, 1945, addressed to the Secretary of the Society, Dr. Edgar P. Copeland, State Chairman for the District of Columbia of the American Academy of Pediatrics, states:

"The Fellows of the American Academy of Pediatrics in the District of Columbia are vitally interested in the new hospital construction now under way here. We are especially interested in planning of facilities for the care of the newborn in the maternity departments of such institutions as well as the improvement of existing facilities in institutions already in operation.

"It is our firm belief that the opinion of the medical profession would most favorably influence authorities charged with this responsibility. It is our further belief that the publication of the enclosed resolutions adopted by the local group of the Academy in the *MEDICAL ANNALS* at the earliest possible date would lend support to this very important subject."

The resolutions adopted by the Academy read as follows:

"The members of the D. C. Section of the American Academy of Pediatrics have familiarized themselves with recent published standards for the hospital care of newborn infants.^{1,2}

¹ Children's Bureau, U. S. Dept. of Labor: Standards and Recommendations for Hospital Care of Newborn Infants, pub. No. 292.

² DUNHAM, E. C., SHAFFER, M., AND MACDONALD, N. F.: Hospitals, 1943, 17, 61.

"In view of the contemplated hospital building in the District of Columbia, with increase in numbers of maternity beds and increased need, therefore, for additional nursery facilities, the following resolutions have been approved:

"1. That hospitals are urged to meet standards for the improved care of infants in order to protect them from infection and facilitate medical and nursing care.

"2. That the staff physicians of the hospitals take the responsibility for seeing that standards are met when plans are being prepared.

"3. That certain standards must be considered minimum, such as

- a. Small nursery units, no one to contain more than eight infants.
- b. Hand washing facilities, i.e., hot and cold running water in each nursery.
- c. A specially equipped nursery for premature infants.
- d. Provision of one or more 'suspect' nurseries.³
- e. Provision of isolation space for infected infants off the maternity floor.
- f. Provision in all nurseries of adequate space to permit individualized care of the infant at the bedside.
- g. Qualified nursing supervision.

"4. That, in larger hospitals, nurseries should be distributed in relation to mothers' units, so that nursing care will be facilitated, the spread of infection will be minimized, and closer mother-baby relationships will be fostered.

"5. That breast feeding should be promoted.

"6. That these recommendations shall be offered to the '*MEDICAL ANNALS OF THE D. C.*' for publication."

³ Mod. Hosp., January 1945.

MEDICAL BOWLING LEAGUE WARMING UP

Five teams out of eight in the D. C. Medical Bowling League are fighting intensely to gain the lead as half of the third series has been reached. Playoffs are held each Friday night from 10:00 to 12:00 p.m. at the King Pin Alleys.

Riding in the lead for the first two series, the Suburbanites were fatally attacked by Sibley No. 2 composed of Drs. Morse, Kirschner, Shea, Katzman and McLain (until his bad knee put him on the sidelines) and Leo Sorel, anchorman, who took 7 of 9 games. Meanwhile Mt. Alto No. 2, with Duffey a dependable 120 average as anchor, crept up to take over the lead by one game on February 16.

Many high games and sets are produced in these hot games. In one, Colonel George Ball, with

145 game and 380 set, and Dr. F. X. Richardson's 376 set, clinched the argument. In another Dr. Gable's 365 set was a big help, and again Major Resta's 141 game and 348 set was a deciding factor. Recently Dr. "Bill" Lewis' 155 and the Suburbanites' 565 game succumbed to the combined firing of Mt. Alto No. 1 with 571. And the lowly 7th place Doctors, comprising Drs. Perkins, Madden, Tabb, Lloyd and Porton, rose up in their wrath and smote Sibley No. 2 with a 582 set.

Then again there are those who express the sentiment of Dr. Dan Washington, who figured he'd better have stayed at home since "they'd get more out of the dummy score than mine."

M. F. O.

War Section

NEWS OF OUR MEMBERS IN SERVICE

Of our recently elected members, the following are serving in the Medical Corps of the Army: Captain Harold R. Feinstein, Major Herbert A. Goldberg and Captain Frank S. Pellegrini. Dr. James R. Hurley, also a new member of the Society, is serving with the U. S. Public Health Service at Medical Center, Springfield, Mo.

Dr. Eugene A. Forcione, who has been commissioned Captain in the U. S. Public Health Service, is with UNRRA in Rome, Italy.

Major Henry B. Gwynn was among the medical officers from the Office of The Surgeon General who attended a conference at Lexington, Va., January 3, 4 and 5, held to consider the organization and operation of convalescent hospitals under the broadened reconditioning program. The conference was addressed by Colonel Augustus Thorndike, M.C., Director of the Reconditioning Consultants Division, Office of The Surgeon General. Attending were Service Command directors of reconditioning and commanding officers of convalescent hospitals.

Congratulations are in order to the following members of the Society who have recently received promotions in rank:

Alfred E. Brigulio, from Major to Lieutenant Colonel

Peter P. Brue, from First Lieutenant to Captain
Frank T. Cawley, from Major to Lieutenant Colonel
William D. Chase, from First Lieutenant to Captain
Karl C. Corley, from Captain to Major
Darrell C. Crain, from Captain to Major
Alva D. Daughton, from Major to Lieutenant Colonel

Oscar H. Fulcher, from Lieutenant Commander to Commander

Edward T. Gary, from Lieutenant Commander to Commander

Alexander Halperin, from Captain to Major
Saul Holtzman, from First Lieutenant to Captain
Edmund Horgan, from Lieutenant Colonel to Colonel

Morris Kleinerman, from Captain to Major
Benjamin P. Lafsky, from Major to Lieutenant Colonel

Wilkins R. Manning, from Captain to Major
Arthur J. Mourot, from Lieutenant Commander to Commander

John H. Peacock, from Captain to Major
F. Daniel Suttentfield, from Major to Lieutenant Colonel

William J. Tobin, from Captain to Major

COMMANDER HOLDEN COMMENDED FOR ACCOMPLISHMENTS

Most of the younger and many of the older physicians in Washington know "Ray" Holden, now Commander Raymond T. Holden, M.C., U.S.N.R. It will come as no surprise to them that he has been awarded the commendation ribbon for his performance of duty as a Senior Medical Officer.

In a release issued to the press by the Public Relations Office, Potomac River Naval Command, on January 29, the circumstances surrounding this recommendation were detailed as follows:

"The commendation ribbon was presented to Commander Holden at a U. S. Navy Base in England on behalf of Admiral

Harold R. Stark, U.S.N., Commander of U. S. Naval Forces in Europe, by the commanding officer of the base. Following is the letter of commendation describing Commander Holden's accomplishments:

"Your performance of duty as Senior Medical Officer of a United States Naval Base in England, during the period prior to and during the leading of landing craft for the assault on the French coast, has been brought to my attention. Your conduct and assistance in caring for the wounded as a result of the bombing of the area near the base by enemy bombers on May 30, 1944, was exemplary.

"By your untiring efforts in organizing, maintaining the base hospital and in equipping the landing craft with medical supplies, you contributed much to the success of the assault. In addition, you established and put into successful operation

in record time a complete dispensary on foreign soil in spite of the many obstacles resulting from long and delayed supply lines.

"For your professional skill and untiring devotion to duty you are hereby commended. This commendation carries with it the privilege of wearing the commendation ribbon. A

copy of this letter will be forwarded to the Chief of Naval Personnel to be filed in your official record."

Commander Holden's daughter, Mary E. Holden, resides at 3111-16th Street, N.W., Washington.

EDITOR'S NOTE: Congratulations, "Ray!"

LETTERS FROM PHYSICIANS IN THE ARMED SERVICES

From Captain Stephen E. Kramer, Lincoln, Nebr.:

Dear Mr. Wiprud: . . . Was interested in your paragraphs on "social medicine." This is a matter I have thought of for many years; probably influenced by my late father (the leading educator of Washington for 46 years, until the day of his death). Dr. Yater can give you some details. About 15 years ago my father addressed the Medical Society on "Social Medicine," or allied subjects, and pointed out then exactly what you state in your letter—that there is an apathy on the part of most physicians towards "organizing" to combat outside unfavorable forces, or to organize themselves as a unit (much like the Army idea) rather than a heterogeneous group of individuals. My father stated that if physicians did not themselves take over the reins, sooner or later they would be the ones who were being led! . . .

From Captain J. Phelps Hand, c/o Postmaster, New York, N. Y.:

Dear Ted: I have had good intentions of writing for a number of months but just when I think the opportunity is right, some obstacle presents itself. It seems to have been ages since I've passed on any news about the situation here in Italy. I think that when I last wrote I was on temporary duty as anesthetist for an auxiliary surgical team and we went from one hospital to another—field and evacuation—with just a brief stay in each spot. I spent three months in that capacity and, of course, did a good bit of work in the "forward" area. During that time I had the pleasure of seeing Florence and can report that it is a lovely city. We got there early in the game and I was able to buy and send home some lovely linen and alabaster. Usually, by the time we who are stationed in the base hospitals get to a new locality, everything worth while has been "snatched up" or prices have skyrocketed to a fantastic figure.

I spent several weeks in the same outfit with J. Beverly Smith, a classmate of mine, who was associated with Dr. Hottel before he went in the Army and we had many pleasant "sessions" together. . .

During the past several months I have been busily engaged in writing a paper which I presented at a medical convention which my outfit put on for delegates from all the hospitals in this theater. The convention was held last week and was quite a success. My paper was on "The Use of Pentothal in Seven Thousand Anesthetics." That is a huge number of cases to report on and the preparation was quite a task because I had to go through the case records, one by one, of almost ten thousand records. Our series of cases is of particular interest

because over 98 per cent of all our general anesthetics have been totally or in part pentothal. It has been truly a wonderful drug and most of the "kinks" have been ironed out since the Pearl Harbor days.



CAPT. J. BEVERLY SMITH AND CAPT. J. PHELPS HAND

I have been quite happy here in my job as Chief of the Anesthetic Section and surely do have a wealth of material. However, now that the news is so good, I'm getting the urge to have this all over with quickly so that all of us can get back to the good old U. S. A.

Before I close, a word of appreciation for your letters! They are my chief source of information so far as Washington is concerned, particularly with regard to the profession, and I look forward to them eagerly.

From Lt. Colonel F. Daniel Sattenfield, c/o Postmaster, New York, N. Y.:

Dear "Uncle" Ted: In reading the "In and Out of Focus," October issue of *Annals*, the article under the caption of "Our Medical Officers" strikes me as still being a bit blurred. Inasmuch as we now have over one third of the nation's (where have I heard that expression before!) physicians in the armed forces, and more are coming, I believe both sides of the ques-

tion should be brought into focus, in an attempt to give a whole truth.

If the expression, "Remember, you are an officer first, a physician second" were more often used and properly explained, there is reason to feel that the young medical officer especially would get off to a good, or better, start. Let us consider a few angles. First, the commission scroll a physician receives upon entering the armed forces is essentially the same as officers entering any non-medical branch of service receive—the branch of service in any instance is the only difference. Second, the primary mission of the Medical Department is "to conserve the fighting strength of the armed forces." It is seen at once that preventive medicine (including hygiene and sanitation) is paramount, and that treating the sick and wounded, however important this is, is really secondary. This is a concept hard to sell to all too many junior medical officers, who, quite frankly, have never been too concerned with the preventive side of medicine. It is a military axiom taught in military schools that it is more difficult to take a healthy army into combat in the field than it is to conduct the tactical operations of battle. The physician entering the armed forces would do well to thoroughly understand this axiom. Once properly understood, physical examinations, mess and latrine inspections, and hygiene and sanitation in general would assume a vitally alive importance.

Third, but by no means less important, it seems to be little understood that many medical officers must hold command and executive posts, far removed from active bedside activities. For example, the commanding officer of a medical unit in a field force must demand the same discipline and precision of his command that a line officer does. He must see that his command is properly trained, fed, clothed, sheltered, equipped, supplied, and is ever ready to perform its mission. Examples: (1) Medical Department personnel (officers must set the standards for others) must wear the uniform correctly and neatly and observe the customs and rules of the military service. (2) Equipment and supplies must be assured at all times. (3) Moving and disposition of medical units in an ever-changing tactical situation. (4) Administrative and medical records must be properly executed and submitted to higher headquarters as required. These are examples wherein the medical officer responsible for such things must be an officer first, last, and always. Can you conceive of a field medical unit bogged down in the field miles away from up where it should be just because the commanding officer (senior medical officer) didn't keep himself informed of the tactical situation? In such a situation, professional service, whole blood and plasma, etc. are criminally dissipated. These and many other such things are taught at our service schools, notably our great Field Medical School, Carlisle Barracks, Pennsylvania. This school operates directly under the Surgeon General, U. S. Army, and I believe that its primary mission is to make medical officers of physicians entering the U. S. Army, or at least to start them off on the right track. Here at this great school, the physician learns the art and science so necessary to his becoming a medical officer, especially if he is to serve with the field forces.

In summary, the old adage of "While in Rome, do as the Romans do" is apropos. In a word, the medical officer would never be out of focus by adopting this motto: "A physician in

all things professional at all times, an officer in all other military matters at all times. These I will blend to complement each other, to the best of my training and ability, at all times."

The concluding paragraph takes the sting out of the main thesis by stating that "these admonitions, though sound, are, as the *Journal* implies, superfluous." Just as the medical personnel played a gallant role in the activities of the "fighting 4-B's" at Bastogne, they are doing it on all fronts in this great struggle. While I in no sense of the word can speak for the Medical Department, I can, and do, happily say that I believe the most illustrious pages in military medical history are being made today. . . .

P.S. The spirit and/or morale of our medical officers and men over here is so high that when a mission seems to be especially hazardous I no longer assign a group of personnel. Rather, I ask for volunteers. To date, all such missions have been oversubscribed to. That is the sort of spirit I refer to, as you would suspect, that is behind these illustrious deeds.

From Comdr. Raymond T. Holden, c/o Fleet Postoffice, New York, N. Y.:

Dear Ted: After all these months I am finally getting around to thank you for the newsy letters. They are most welcome and I get quite a kick out of reading about all the happenings in Washington which you pack into them. The *Annals* also arrives regularly if a bit late. . . .

I inherited this job in November. It is entirely staff work. . . . I get around the country a bit on inspection trips so that helps. What I miss most is the patients I used to have. At my last station I had a good sized dispensary which I had organized, built and run for more than a year. I got a chance there to treat a few patients and even though some of the surgery I did was not in the field of obstetrics or gynecology, the patients got along remarkably well and the results were very satisfactory.

Practically all of us are agreed that some change in practice is necessary. We have experienced, at first hand, group practice during our service experience and we like it.

I have another scheme of my own which I have seen work over here with the panel system in operation but I will keep it for a future discussion with you. Suffice it to say that it is nothing new or revolutionary, merely the application of a few fundamentals.

. . . Remember me to all of my good friends in the Society. I would like particularly to be remembered to the good Board members with whom I served so long. . . .

From Lt. (j.g.) Charles S. Coakley, c/o Fleet Postoffice, San Francisco, Calif.:

Dear Ted: I have enjoyed receiving your newsy letters very much and I thought I would write and tell you so. It sounds like you have been very busy and I was glad to hear that the Assembly was such a success. It's reassuring to know that definite steps have been taken by the Society to cope with the problems of postwar medical care. Your Committee on Medical Care has a capable chairman and I know Frank will get the ball rolling.

I thought you might be interested to hear about this evacuation hospital. In August 1944 I was detached from

my duty as anesthetist at Bethesda to join this corps evacuation hospital. This is the first corps evacuation hospital the Marines have tried and was partially the brain child of Captain Don Knowlton who is here as the Division Surgeon. For the past six months we have been training and organizing our hospital at Lejeune, Pendleton and on November I left for this island. We have a well trained group of medical men, almost all specialists, representing any specialty you can think of. I am the anesthetist and have been training corpsmen to help out with the anesthetics, the gas therapies and blood, plasma and serum albumin infusions. We should see lots of interesting medicine.

We are all in good condition due to daily exercises and swimming. I heard that Bill Meley was back in practice after being over here two years with the Marines. The story he told, which I heard via the bridge table gossip, about recreational facilities for the G.I.'s was news to me. Ours has been limited to evening movies and our wine-mess.

Most of the Society's mail has reached me, having been forwarded by Mrs. Coakley, but I would appreciate your mailing to this new address. Haven't seen a copy of *Medical Annals* for quite a while and would appreciate your sending that on too.

It surely was good news to hear that G.W. is really getting a new hospital. As you said, Washington's hospitals have been out-dated and with these new medical facilities it gives those of us overseas an incentive to return, take over our teaching appointments and make D. C. a real medical center. I am anticipating a real anesthetic service in our new hospital.

Best regards to all. If you see Jimmy Malone tell him the service station situation out here is about like his—you service your own jeep.

From Major William J. Tobin, Framingham, Mass.:

Dear Mr. Wiprud: . . . We are still very busy up here in New England. The weather continues to be very cold, and there has been snow on the ground since before Christmas and no doubt will continue until later on. In all the weather isn't too bad. While it does snow in Washington, the snow does not remain on the ground as it does up here in New England. Kindly remember me to Dr. Yater and all of my friends in Washington. . . .

From Lt. Jack L. Derzavis, Miami, Fla.:

Dear Ted: During most of my thirty-two months of active duty I have perused your delightful and informative letters which have come my way and I feel that I have been rather perfunctory in my correspondence, recalling only one occasion wherein I came up for air long enough to reply. . . .

I think that you are rendering a great service to all of us in the armed forces. . . . So please continue to send your warm greetings and references to places at home—I can readily visualize, for example, Peoples Drug Store on Connecticut near M Street on a cold winter's day. By the way, does the facade of 1150 Connecticut look as gray and cheerless as ever? Are all the doctors now replaced by dentists at 1726 Eye? I wonder if the colored boys in the parking lot are still banging up the fenders. Oh, how I'd like to have mine banged up once more and not mind because there'd be no problem of obtaining new ones! All these little silly things—like Cy Ellis' place on

the wharf and a heaping bowl of crab meat and that cold stein of Budweiser after a Monday night clinic at the Southwest Health Center—and many more, seem much farther back than three years.

I can't complain though. This war has opened up an entirely new vista for me. In my capacity as a venereal disease control officer I have been busy organizing extra as well as intra-naval programs wherever I have been and, right now, I am tied up in a many faceted undertaking along these lines here in the greater Miami area. There is so much to be done and one has to be a competent salesman to put over something that is begging for recognition. And then, there's always the fear of frustration and wasted time. Believe me, the Treponema and Gonococcus are tough babies to fight, too.

My job has carried me to many places throughout the Southwest and South: Corpus Christi, Laredo, El Paso, Mexico, Houston, New Orleans, St. Louis, Atlanta and all over Florida. It has not been difficult to realize the need for better education especially in preventive medicine and venereal disease control. One becomes sociologically and economically conscious in a very brief time. The importance of medical public relations is most evident. I do hope I can continue this work if I am able to eventually return to private practice in Washington. I fear too few physicians realize that their privilege to practice entails a compensatory duty to their community. This subject could well be incorporated in the undergraduate medical curriculum. . . .

* * *

I should like to congratulate you in your important position as head of the faculty of Medical Socioeconomics. The practicing professional in our field has too long neglected this very important facet of medicine which has been fully recognized many years by the administrative workers.

I am particularly interested in your curriculum: Relationship of the Private Practitioner to the Health Department, The Doctor's Role in Public Affairs and Social Agencies and Their Relationship to Medicine. In my nearly three years of venereal disease control work in the Navy I have become increasingly cognizant of these three phases of medical public relations and I am particularly happy to read the "Observer's" comments about them.

I am convinced that the most important factor in venereal disease control is an adequate educational program. Irrevocably intertwined in this educational effort are social, economic and political backgrounds crying for solution.

Consequently, I should like to suggest a consideration of this subject, "Venereal Disease Control," as a possible future member of your adroitly chosen subject group. Washington has the advantage of governmental and lay agencies such as the Army, Navy, U.S.P.H.S., Social Protection Division of F.S.A. and the American Social Hygiene Association, Inc., which would undoubtedly be anxious to help organize and maintain the course.

The doctor, for his privilege to practice in society, owes that society a program which he alone, by the very nature of his training and experience, can fulfill. It is gratifying to learn that even the prohibitive exigencies of war have not retarded the progress of medical education and that the future doctors will undergo specific training which will direct their efforts toward compensating their debt to mankind.

On The Home Front

The American Psychiatric Association announces the cancellation of its 101st Annual Meeting, which was to have been held in Chicago during May, to conform with the new regulations of the Office of Defense Transportation. A meeting of the Councilors of the Association took place on February 26 and 27.

The Section on Neurology and Psychiatry held a meeting in the Society's library, March 1, to which all members of the Society were invited. The program, which consisted of the following papers, was dedicated to Latin-American neuropsychiatry: "The Present Status of Electroencephalography," Dr. Abraham Mosovich of Argentina, Research Associate at Saint Elizabeths Hospital; "Psychiatry in Brazil," Dr. Oswaldo Camargo, Psychiatric Inspector for the Brazilian Public Health Service. Drs. David McK. Rioch and Winfred Overholser discussed the papers.

On February 1 the Section presented the following program: "Neurological Changes in Polycythemia," Drs. Antonio Gonzalez-Revilla and Walter Freeman; "Psychoses in Naval Inductees," Lt. Otto A. Will, Jr., M.C., U.S.N.

More than 350 members and guests attended the 19th Annual Dinner of the George Washington University Medical Society, which was held February 17 at the Mayflower Hotel. Rear Admiral Thomas Leigh Gatch, Judge Advocate General, U. S. Navy, was guest speaker. Dr. Robert H. Harmon, President of the Society, presided. Vocal numbers were rendered by the George Washington University Glee Club.

The Washington Ophthalmological Society met in the Medical Society's building, March 5. "War Ophthalmology" was the subject of an address by the guest speaker, Colonel Derrick Vail of Cincinnati, Ohio. Dr. Benjamin Rones gave a case report on "Anomalous Vascular Loop in the Macula." Case presentations were made by Drs. Joseph

CALENDAR OF MEETINGS

February 1	Section on Neurology and Psychiatry
February 5	Subcommittee on Insurance of Executive Board
February 7	Board of Censors
February 8	Committee on Medical Care
February 9	Special Building Committee
February 12	Committee on Public Policy
February 14	Scientific Meeting of Society Subcommittee on Mental Health
February 15	Subcommittee on Venereal Disease
February 23	Nominating Committee
February 26	Executive Board
February 28	Scientific Meeting of Society

Dessoff, Thomas Rees, Frank D. Costenbader and Benjamin Rones.

Dr. Janvier W. Lindsay was host to the Clinico-Pathological Society at its meeting, February 6, at the Kennedy-Warren Apartments. Captain Winchell M. Craig, Chief of Surgery, National Naval Medical Center, spoke on "Neuro-Surgical Problems of Warfare." Dr. William H. Hough read a paper on "Post-Arsphenamine Jaundice."

The Executive Board, at its meeting January 29, 1945, appointed the following subcommittee to select the Davidson Lecturer for 1945: Dr. William Earl Clark, *Chairman*; Drs. A. Magruder MacDonald, Fred R. Sanderson, Henry C. Schreiber and Coursen B. Conklin.

The following additional appointments were made to the Committee on Medical Care: Drs. Norvell Belt, Daniel L. Borden and Henry L. Darner.

The name of the Committee on Rehabilitation of Service Physicians was changed to Committee on Service Physicians.

The following members were appointed to mem-

bership in Health Security Administration for a period of one year:

Truman Abbe, Harry S. Bernton, Charles J. Bowne, Earle G. Breeding, Leo T. Brown, Charles B. Campbell†, Arthur C. Christie, Henry J. Crosson, Russell J. Fields, Frank A. Hornaday, Vincent Hungerford, Oscar B. Hunter, Thomas F. Collins, Elizabeth A. Kittredge, Henry C. Macatee, William B. Marbury, F. X. McGovern, W. Cabell Moore, Margaret M. Nicholson, Leo B. Norris, Joseph W. Peabody, Herbert P. Ramsey, John A. Reed, Henry R. Schreiber, Joseph P. Shearer and Joseph S. Wall.

Dr. Henry C. Macatee, President of Health Security Administration, presided at the organization's annual meeting, January 30. Two new trustees were elected: Dr. William M. Ballinger of the Medical Society and Dr. William Eccleston of the Dental Society. Among Medical Society members re-elected trustees were Drs. Macatee, Watson W. Eldridge, Oscar B. Hunter and Margaret M. Nicholson.

Children's Hospital, the Episcopal Eye, Ear and Throat Hospital, Washington Home for Incurables, and the Washington Society for the Hard of Hearing were among the organizations to receive \$1,000 each under the terms of the will of Mrs. Mary D. H. Kendall, who died December 27 at the age of 85, leaving an estate valued at more than \$352,000. These institutions may receive further funds after certain other bequests have been provided for.

The Medical Advisory Board of the American Legion is conducting a Nation-wide public health campaign designed particularly to aid discharged servicemen and their families, and through them the public at large. Colonel Leonard G. Rowntree, Chief of the Selective Service Medical Division, is Chairman of the Board, which consists of Major General George F. Lull, Deputy Surgeon General of the Army; Rear Admiral William J. C. Agnew, Assistant Chief of the Bureau of Medicine and Surgery; Colonel Esmond R. Long, Executive Officer, Office of the Surgeon General of the Army; Captain Raymond C. Wells, U.S.N., Assistant Chief of Selective Service Medical Division; Lt. Colonel Charles W. Mayo of the Mayo Clinic; Dr. William D. Stroud, Professor of Cardiology, University of Pennsylvania; Dr. Winfred Overholser, Superintendent of Saint Elizabeths Hospital; Lt. Colonel

Louis H. Renfrow, Executive Officer, Selective Service Medical Division, and Dr. A. N. Baggs, American Legion medical consultant, ex officio. The Committee is holding monthly meetings.

The Mile o' Dimes Committee for the District of Columbia reported that the proceeds from the 1945 campaign surpassed the 1944 drive by approximately \$31,000. The total amount collected as of February 17, 1945, was \$94,500. The Committee expressed its appreciation to the Medical Society for the contributions made by its members.

Major General Merritte W. Ireland was awarded the William Freeman Snow Award on February 7, in Chicago, for "distinguished service to humanity." The award was established in 1937 and is given annually by the American Social Hygiene Association. Announcement of the presentation was made by General John J. Pershing, who is Chairman of the Association's Committee on Awards.

General Ireland entered the Army medical corps in 1891. He became Surgeon General of the Army in 1918, serving in this capacity until his retirement in 1931. During his term of office he reorganized the Surgeon General's Office in line with the experience he had gained during World War I and laid the foundation for the present Army medical program. Through his efforts the Field Service School at Carlisle Barracks, Pa. was established. He also was responsible for the development of the Army Medical Center at Washington, D. C., and of Army hospital facilities.

General Ireland is an Honorary Member of the Medical Society of the District of Columbia.

Rear Admiral Edward R. Stitt, former Surgeon General of the United States Navy, has been awarded the Richard Pearson Strong Gold Medal and an honorarium of \$500 for outstanding service in the field of tropical medicine. The presentation was made at the University Club, New York, February 5, by Colonel Richard Pearson Strong, M.C., Director of Tropical Medicine at the Army Medical School, Washington. The medal and honorarium were established in 1944 by the Winthrop Chemical Company as an annual award for distinguished service in tropical medicine.

Admiral Stitt served as Surgeon General of the

† Died February 5, 1945.

United States Navy from 1920 to 1928 and held professorships in the schools of tropical medicine at Georgetown University, George Washington University and the University of the Philippines. He was a lecturer at Jefferson Medical College, Philadelphia, and a lecturer and commanding officer of the U. S. Naval Medical School. Since 1941 he has been a lecturer on tropical medicine at the Army Medical School.

Dr. J. Ross Veal addressed the Baltimore City Medical Society, February 16, on the subject, "The Surgery of Peripheral Venous Thrombosis."

Dr. Winfred Overholser addressed a meeting of the Brotherhood of the Washington Hebrew Congregation, February 21. His subject concerned psychiatric disabilities of servicemen who are returning to civilian life.

Among prisoners of war released from a Nazi prison camp by the Soviet Army when it entered Poland was **Dr. Vincent Di Francesco**, 3356 Pennsylvania Ave., S.E. Dr. Di Francesco graduated from George Washington University School of Medicine in 1940 and interned at Providence Hospital. He has been in service three years.

Mrs. Charlotte G. Foley, wife of Dr. Thomas M. Foley, christened the destroyer U.S.S. Gearing, which was launched February 18 at the Federal Shipbuilding and Dry Dock Company, Kearney, New Jersey. The destroyer is named in honor of her father, Comdr. Henry Chalfont Gearing, U.S.N., retired; her brother, the late Captain H. C. Gearing, Jr.; and her nephew, the late Lt. H. C. Gearing III, U.S.N.

MEETINGS

Wednesday, April 11

PREVENTIVE MEDICINE (15 min.): "Preventive Nutrition," LT. COMDR. C. M. McCAY, U.S.N.R., in charge of Nutrition Studies, Naval Medical Research Laboratory, Bethesda, Md.

The Section on Pathology and Laboratory Medicine will sponsor the program following the talk on preventive medicine.

Wednesday, April 18

SCIENTIFIC MEETING

Speakers and subjects to be announced.

CORRESPONDENCE

WASHINGTON, D. C., February 16, 1945

TO SUPERINTENDENTS OF WASHINGTON HOSPITALS:

Your attention is invited to an Act of Congress known as Public No. 491, 78th Congress, approved December 16, 1944, which provides:

"Permits issued by the Health Officer or any duly appointed deputy for the removal, interment or disposal of such dead body or part thereof shall be issued only upon the presentation of a proper death certificate, signed by a physician registered at the Health Department of said District, who has attended the deceased during his or her last illness, or by the coroner of said District or his deputy."

Accordingly, you will be required to have the physician who has last attended any patient dying at the hospital sign the certificate of death unless there is reason that the Coroner or his deputy should have been called to certify as to the cause of death.

Very sincerely,

GEORGE C. RUHLAND, M.D.

Health Officer for the

District of Columbia

cc The Medical Society of the District of Columbia

WASHINGTON, D. C., January 26, 1945

MR. THEODORE WIPRUD

SECRETARY, THE MEDICAL SOCIETY

OF THE DISTRICT OF COLUMBIA

WASHINGTON, D. C.

DEAR MR. WIPRUD:

Your wonderful coöperation during our recent Nurse's Aide drive has produced the kind of results for which we hardly dared hope. We have gone over the top with more than 275 day aide registrants and 360 night aides. Our goal as you know was for 250 day aides.

We hope that now we may be of far greater service to our District hospitals.

Thank you so much for helping all of our departments, radio, press, and speakers bureau. If we can ever be of service to you please call on us.

Sincerely,

REBEKA FITZGERALD (MRS. EDWARD J.)

Director, Public Relations Dept., American Red Cross, District of Columbia Chapter

WASHINGTON, D. C., January 25, 1945

DEAR MR. WIPRUD:

The members of the Executive Committee of the District Red Cross Nurse's Aide Corps wish to join me in a few words of thanks to you for your invaluable help to us in our recent drive to recruit more Nurse's Aides.

That day that I had the pleasure of meeting you and talking to you in your office, I was hopeful that if the drive was based on a professional appeal for more help, we would get results; but in my wildest dreams I never dared hope for the kind of response that we have had.

I think it would interest you to know that as a result of the drive we have interviewed and filed applications of over five hundred women. Nine classes for daytime aides, each class starting with thirty-three women, have been scheduled, and four classes of night aides. One of the day classes is already under way, one starts Monday at Bolling Field, six start the first week in February, and one the first week in March. Three of the night classes start the first week of February, and one in March.

We are all very pleased, and also slightly exhausted. And again please accept our deepest gratitude for the very large part that you played in our campaign.

Very sincerely,

GENEVIEVE CARPENTER HILL (MRS. PATRICK C.)
*Chairman of the District Chapter,
Red Cross Nurse's Aides*

EDITOR'S NOTE: Several months ago a portrait of Robert Morris, signer of the Declaration of Independence, was found in a storage room in the Society's building. It was in such bad shape it was thought nothing could be done with it. However, the portrait was taken to the Smithsonian Institution where it was offered to the National Collection of Fine Arts. Only recently Mr. R. P. Tolman, Acting Director, informed the Society that the picture had been restored but it was not acceptable to the National Collection of Fine Arts. However, he stated that the United States National Museum would like it. The Executive Board directed that it be given to the Museum and the following acknowledgment of the gift was received:

WASHINGTON, D. C., January 26, 1945

MY DEAR MR. WIPRUD:

Referring to your recent correspondence with Mr. R. P. Tolman it is with pleasure that I make formal acknowledgment of the receipt of a portrait of Robert Morris (1774-1806).

This interesting portrait has been assigned to our Division of History and been entered on the records of the Museum as a gift, through you, from the Medical Society of the District of Columbia and I would assure you of our appreciation of your thoughtful interest in rescuing it and turning it over to the national collection.

Very truly yours,

J. E. GRAF

Associate Director,

United States National Museum

BOOKS RECEIVED FOR REVIEW

Uncle Sam Convalescing—A Glimpse into His Hospital Record from 1933-1940. H. AMEROY HARTWELL, M.D. Price, \$2.00. Pp. 79. Boston: Bruce Humphries, Inc., 1945.

A Textbook on Pathology of Labor, The Puerperium and The Newborn. CHARLES O. MCCORMICK, A.B., M.D., F.A.C.S., Clinical Professor of Obstetrics, Indiana University School of Medicine; Consulting Obstetrician to William H. Coleman Hospital for Women, Indianapolis City Hospital, and Sunny Side Sanitarium. Price, \$7.50. Pp. 399, with 191 illustrations. St. Louis: Mosby, 1944.

Poet Physicians, An Anthology of Medical Poetry Written by Physicians, compiled by MARY LOU McDONOUGH. Price, \$5.00. Pp. 211. Springfield, Ill.: Thomas, 1945.

The March of Medicine, No. IX of The New York Academy of Medicine Lectures to the Laity, 1944. THE COMMITTEE ON LECTURES TO THE LAITY: Charles Diller Ryan, M.D., *Chairman*, Frank Fremont-Smith, M.D., and Philip Potter, M.D., representing the Committee on Medical Information; Alexander T. Martin, M.D., George F. Cahill, M.D., and George G. Ward, M.D., representing the Committee on Medical Education; and Wilson G. Smillie, M.D., representing the Committee on Public Health Relations; Iago Galdston, M.D., Executive Secretary. Price, \$1.75. Pp. 121. New York: Columbia Univ. Press, 1945.

Modern Methods of Amputation with an Introductory Survey of the Development of Amputation by Major General Norman T. Kirk, M.C., Surgeon General, U. S. Army. EDMUNDO VASCONCELOS, Professor, University of Sao Paulo. Price, \$10.00. Pp. 253. New York: Philosophical Library, Inc., 1945.

CHARLES BERGER CAMPBELL, M.D. (1870-1945)

Dr. Charles B. Campbell, well known physician and a leader in civic activities, died at Emergency Hospital, February 5, 1945, after a brief illness. He resided at 1731 Lamont Street, N.W., and maintained his office in the Farragut Medical Building.

Dr. Campbell was born in Quakertown, Pa., August 30, 1870; at an early age he moved with his parents to Virginia, receiving his elementary training at Leesburg Academy. In 1891 he graduated from George Washington University School of Pharmacy and in 1894 from Georgetown University School of Medicine. Dr. Campbell was for several years the proprietor of several local drugstores. Later he devoted his entire time to the private practice of medicine, specializing in dermatology. His career in pharmacy and medicine extended over half a century.

The Medical Society of the District of Columbia, with which Dr. Campbell had been affiliated as an Active Member for 23 years, selected him as its official Delegate to the Federation of Citizens' Associations in 1929 and he served continuously in that capacity until last November, when he retired because of ill health. For the last twelve years he held the Chairmanship of the Health Committee. In appreciation of his "outstanding public service for the District of Columbia" in the field of community health and health legislation, the Federation, in April, 1944 awarded him the Evening Star Trophy, a silver cup presented annually.

Dr. Campbell was a Fellow of the American Medical Association. He had held the office of president of both the Veteran Druggists' Society and the Mount Pleasant Citizens' Association. He held membership in Federal Lodge No. 1 of the Masonic Order and had long been an active member of the Calvary Methodist Church.

Surviving are his wife, Mrs. Lotta R. Campbell, and one daughter, Mrs. Robert R. Johnson of Philadelphia, Pa.

Thyrotoxicosis—Burke

(Continued from page 109)

gram repeated 12 days after initiation of this treatment showed a normal record. At the end of 2 weeks, also, her pulse rate remained consistently lower, despite activity around the ward. The thyroid gland was thought to be smaller, the staring expression and lid lag disappeared, and the exophthalmos became less prominent. She felt well, and at the time of discharge on September 8, 1944, 50 days after admission, she weighed 77 lbs. Subsequent basal metabolic rates

taken at weekly intervals were minus 6 and minus 4 per cent.

The patient was seen in the outpatient department 3 weeks after discharge, having been sent home on a maintenance dose of 0.10 Gm. a day of thiouracil. The basal metabolic rate at this time was plus 5 per cent.

Subsequent examinations made at weekly intervals revealed the patient to continue in good health; she had gained 20 pounds over a period of 2 and a half months, the length of time she had been on thiouracil. The drug was discontinued for 1 week, 5 weeks after discharge from the Hospital because of leukopenia (3,900), with, however, a normal differential hemoglobin and red blood cell count. Seven days afterwards it was begun again at the previous dose, the white count rising to 10,000. Observation will continue at weekly intervals and she will receive brewer's yeast and liver extract (as recommended by Williams and Clute⁶).

I am indebted to Dr. Edward Brooks and to Dr. Joseph S. Wall for the privilege of reporting this case.

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Polycythemia Vera—Cooch

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Choledochoduodenal Fistula—Yater and Moser
(Continued from page 116)

Necropsy revealed a hard mass about 7 by 10 by 5 cm. involving the tissues in the region of the head of the pancreas in such a way that it was impossible to determine where the neoplasm originated. The head of the pancreas was impli-

cated. On cut section the tumor was white and shining. When the duodenum was opened along its anterior surface the ampulla of Vater was found to be transformed into an indurated ulcer with curled edges. The center of this ulcer was occupied by an orifice about 3 mm. in diameter which communicated with the common bile duct. The latter was dilated to about 3 cm. in diameter, and its wall was 2 to 3 mm. thick. The gall bladder appeared to be chronically inflamed but did not contain stones. The body and tail of the pancreas were enlarged to between 2 or 3 times normal size, and the ducts were greatly dilated and obstructed at the ampulla of Vater. The liver weighed nearly 3,000 grams, was soft and mushy, and contained an abscess 8 to 9 cm. in diameter in the right lobe near the diaphragmatic surface. Its wall was 3 to 4 mm. thick, and it contained 50 to 60 c.c. of greenish gray, foul-smelling material; it connected with a biliary duct. The spleen weighed 350 grams and was almost semifluid. The mesenteric lymph nodes were enlarged and on section appeared to be neoplastic. Dr. Whitmore states that the neoplasm is a reticulum-cell sarcoma.

DR. YATER: A reticulum-cell sarcoma invaded the tissues in the region of the head of the pancreas and duodenum, caused an ulceration of the ampulla of Vater, and ruined that structure in such a way that the duodenal contents could enter the common bile duct. Infection ascended through it into the liver and produced an abscess. The barium meal filled the biliary ducts but did not fill the abscess cavity. The jaundice was the result primarily of obstruction of the common bile duct by the tumor. Later, when the fistula developed, it diminished, but some jaundice persisted then because of hepatocellular damage. Death was precipitated by the liver abscess before the sarcoma became widespread and metastasized remotely. Such a rare condition could not have been diagnosed during the life of the patient.

In and Out of Focus—Observer

(Continued from page 128)

No, doctor, you can't buy "salvation." You must think, work and fight for it. For it comes only to those who earn it.

★

*Oklahoma
Tells 'Em*

One thing we expect of Westerners is straight-forward speech. What they have to say they usually "lay on the line." This may at times be a little shocking but one is never in doubt where the Westerner stands. Of course, this rule does not apply to all of his kind but it is quite as characteristic as his friendliness of manner.

Reflecting this spirit, the *Journal of the Oklahoma State Medical Association*, in its January number editorializes as follows:

"We are proud of the part played by members of the medical corps at Bastogne. . . . We are proud of Brig. Gen. McAuliffe who, in response to the German ultimatum, immortalized American slang when he unhesitatingly flashed into the teeth of the mongrel mutts, the one stinging word, 'Nuts.'

"Appropriating the word with its glorified meaning, the doctors in Oklahoma [say to] all ambitious politicians who would ruthlessly over-run the patient-doctor-God relationship. . . 'Nuts.' "

That's telling 'em.

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Philadelphia

ENROLLMENT FORMS HAVE BEEN MAILED TO ALL MEMBERS

MEDICAL ANNALS

of the
DISTRICT OF COLUMBIA

VOLUME XIV

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A PSYCHIATRIST LOOKS AT CONSTITUTION AND ENVIRONMENT AND IS PUZZLED*

BEN KARPMAN, M.D.

Washington

UNLESS the practicing physician resigns himself to becoming a mere automaton in the handling of the patient, mechanically eliciting symptoms, making tests, and prescribing routine treatment, he must perforce stop at times and reflect on the meaning of his activities. There are a great many problems associated with such activities, but there is none that carries such a large meaning for the practitioner as the problem of constitution and environment. The problem presents itself in many forms and in many disguises, the most frequent and open being that of resistance and infection, of the host and the parasite, etc. Why is it that in some instances a seemingly minimal exposure to infection produces a most virulent form of disease, while in other instances the patient, even with a large exposure, completely escapes? It must be a relation between infection and resistance, which in basic terms means environment and constitution. The environment may mean not only the invading germ, but many external factors as well, plus the psychophysical state of the host; it must further include the soil which is the hereditary background and the constitution.

The following considerations pertain primarily to psychophysical problems which come within the domain of psychiatry. It is submitted, however, that the mind is merely another aspect of the body, both being expressions of one indissoluble entity, and that the same basic principles operate in one as in the other, so that these considerations have an equal bearing on medicine in general.

As yet we know very little of the meaning of the human constitution although the need for such knowledge is great, as evidenced by the frequent use of the term. Psychiatrists, in no wise different from the rest of physicians, have been rather loose with the term, often using it to denote a condition that is so deeply ingrained as to be unmodifiable by training and uninfluenced by experience, and which, therefore, for practical purposes, amounts to being constitutional. This is certainly unpardonable semantics, since it means that something that is less than one or even different from one is regarded as equal to one. Perhaps the best illustration is the use (or misuse) we make of it in the condition which had been commonly defined as constitutional psychopathy; for no one has actually been able to prove that this condition is really constitutional.

* Read before the Section on Neurology and Psychiatry of the Society, December 7, 1944.

Or the term constitutional depression is used when it is meant that the individual always seems to be in a depressive mood and has been so for as many years back as he can remember, although we have no way of knowing whether the reaction is, in essence, constitutional, or whether it has been ingrained in the individual from the earliest childhood. And if it be legitimate to call these conditions constitutional, couldn't we, with equal justification, also call schizophrenia and cyclothymia constitutional, seeing how extremely resistant these conditions are to treatment, especially in terms of basic change? Furthermore, psychoanalysis has shown that many reactions long thought of as being inborn and constitutional, are often revealed as being fundamentally due to early environmental influences, as in the case of many sexual perversions.

It would seem, therefore, superior and safer on many grounds that until we know more about the nature of constitution, the term "constitutional" be entirely omitted from any consideration of diagnosis. This should not mean, however, that some conditions may not, eventually, prove to be constitutional, nor that we should omit from our discussion the consideration of the problem of constitution. Freud has consistently referred psychologic problems to constitution and has spoken of the constitutional basis of compulsion neuroses, the biologic aspects of homosexuality, and the somatic aspects of anxiety neuroses. Jelliffe speaks of structure as being organized function, a concept that finds support in pathology, which insists that disturbances in function precede disturbances in structure.

For the most part, what we know at present of constitution refers mainly to definite situations: specific asymmetries, gross malformations and obvious developmental defects. Of constitution as a whole, precious little is known. We should like to subsume under this heading the totality of relationship existing from birth between the various systems, organs and tissues of the body, the manner in which they are physically and

functionally integrated to produce a whole. Pathologic constitutions are numerous. We refer to the instances of individuals who on gross observation or on even more careful examination fail to show any obvious anomalies, yet whose whole life adjustment, in terms of psychologic behavior, is more than merely peculiar; it is quite out of joint with the rest of the stream of the social milieu in which they move. Such psychologic failure to adjust must be expressive and concomitant of some basic physical deficiencies which, instead of being gross defects, consist of some changed relationship between various systems, organs and tissues. Assuming (though by no means subscribing to or concurring) with Hess and Eppinger that the vegetative nervous system consists of two separate, functionally opposed parts, the autonomic vagotonic and the sympathicotonic, and that on this basis human beings may be divided into two respective groups, it will have to be further assumed that normally these two systems stand in definite quantitative relationship to each other, say as $x:y$. It is not difficult to see that if through some developmental error the proportion is changed to, say $.9x:1.1y$, then this would make for a tremendous change in the reaction of the personality as a whole. These innervations are distributed normally in fairly definite ratios to various organs of the body, heart, lungs, liver, intestines, etc., but even if only one of these organs should receive more than its normal supply of one of these innervations and proportionately less of the other, this, conceivably, would be enough to upset the normal equilibrium and hence the individual's total behavior. In like manner, one might discuss the functional relationship between various endocrine organs. Because of the fact that these are so interdependent, if the function of only one of these secretions is disturbed, it would be sufficient to disturb the functions of the rest of the endocrine system and produce a behavior that is markedly at variance with the rest of the members of the community, and spell

definite illness, diabetes in the physical field, manic-depressive psychosis in the mental field, as the case may be.

The accumulated evidence in psychiatry points strongly toward the possibility that heredity plays a large role and that mental diseases often run in families. Yet one will have to account for those instances, all too numerous to be regarded as accidental, where the family background traced for several generations appears to be free from psychopathic determinants, yet out of a clear sky as it were, there develops an undoubted case of manic-depressive, schizophrenic, or other form of psychosis. Somewhere along the embryologic development a change in the relationship between body systems, organs and tissues must have taken place, resulting in a labile constitution. But what it is and how it comes about, we can hardly even guess. Other instances are also known in which the hereditary component, though definite, was very small; yet one of the progeny developed an extreme case of psychosis that ended disastrously. I cite here the instance of an individual in whose heredity, direct and collateral, I was able to uncover but one instance of abnormality, a maternal uncle who appears to have been of a definite cyclothymic make-up, though actually never confined to an institution. Yet one nephew developed a most virulent form of manic-depressive psychosis that, in spite of all precautions taken, finally ended in suicide. Do his siblings who have escaped such a fate carry mental disease as a recessive? Definitive work along this line is still lacking.

And here is another clinical instance of a married man, a preacher by profession, who had 10 children. He appears to have made an entirely normal adjustment without exhibiting any obvious aberrations. However, there is recorded an incident at the age of 30 when he went through a very transitory hallucinatory episode lasting but 2 hours during which he heard God and angels speak to him. The episode quickly passed leaving no trace whatsoever; nor did it ever recur. All of the children but 1 developed

entirely normally. The 1 exception was a son who developed a most virulent form of hebephrenic psychosis in which state he has been for the last 20 years with little likelihood of recovery. It seems as if the minimal abnormality in the father missed all the children but 1, but endowed that 1 with a greatly exaggerated abnormality. Is there such a thing as exacerbation or summation of genes?

We have a similar reflection and speculation on the nature of hysteria, and it is unfortunately equally vague, to wit, hysterical paralysis. Here is a woman both of whose legs are paralyzed from the hips down. A most careful physical examination fails to reveal the presence of any factor or set of factors that could in any way be regarded as causative pathology. On the psychologic side it is learned that there are strong unconscious reasons why she should not want to move her legs; she could gain, from her point of view, great advantages from her environment by being sick in this particular manner. This is well enough psychogenically, but what about the anatomic and physiologic background that makes such a reaction possible? There are, no doubt, many people in similar life situations who also would have wished to have a like disease, but they cannot make it. Perhaps psychogenesis is not enough. Perhaps it requires a particular type of neuromuscular system that would enable one to thus act; the wish alone is not enough. In some ways these particular neuromuscular and vegetative autonomic systems serve as agents and media through which the unconscious wish of the individual is expressed at the psychologic level. Yet even this formulation leaves much to be desired.

Or, to cite another instance of a young male merchant who, after having given a deposit on a business he expected to buy, was immediately precipitated into an acute hysterical state expressive of his inability to assume responsibility. An analysis of a year and a half cleared him of all symptoms and he was able fully to assume all the necessary responsibilities. Things moved well

for a year, when seemingly out of the clear sky he was precipitated again into the state that originally brought him to my attention. Not a single symptom was missing; it was as if all of the analysis had been completely wasted. The immediate precipitating factor appeared to be the marriage of his only sister. Now, in the course of analysis it was clearly brought out that he was fixated on his sister, which fixation was a transference from his mother. At the time of his discharge from analysis the sister did not present any emotional threat to his future. She was unattractive, tall, ungainly, almost gawky, with a narrow face, and a nose so thin as to give the face a most unappealing expression. At the advice of a friend this sister had a plastic operation performed on her which changed her entire appearance. Within 3 months she was married, and it was this marriage that precipitated the patient's second breakdown. The original analysis could not, of course, foresee marriage of the sister, nor even guard against its likelihood. It was not, of course, difficult to bring him back to normalcy, and he has remained well adjusted 8 years after discharge. The case, however, raises a most important question. Why is it that the analysis, otherwise entirely successful, was so helpless in preventing the return of at least one set of symptoms? It seems that the man has a particular nervous pattern which he must act out in full whenever he is confronted with an acute and threatening situation. Analysis can help him to adjust at a superior level, but it cannot change his pattern. That, we take it, is constitutional; otherwise, we could expect the children of analyzed neurotics to be normal. Alas and alack! All too often they are entirely neurotic, though admittedly the insight gained by the parents often modifies the neurotic expression.

In clinical psychiatry, there has long been current the speculation that the ability of the catatonic patient to maintain unusual physical postures and body attitudes for long periods of time (so-called waxy flexibility), something that

a normal man cannot do, results from a changed proportion between the striped and unstriped musculature in the arm, there being more of the latter. Again the heart, in many a case of dementia praecox, is very small, and with it goes a smaller vascular tree. It is obvious that such an individual, whatever else may be wrong with him, cannot function in a normal manner.

How many of the average population could conceivably will and reproduce a perfect epileptic fit? No one could do it even if offered any emolument, however advantageous; yet I had 1 patient who would do it at will any time for 10 cents. I had another patient who could "throw" a most perfect convulsion except that he couldn't produce any frothing at the mouth. For this, he used powdered soap. But the ability to do that was there and it would seem that it must be constitutional.

The constitutional factor in manic-depressive psychosis appears to be a disturbance in the endocrine functions. It seems as if the latter, perhaps through the adrenal-thyroid system, instead of functioning regularly, works irregularly, now in excess and much more than normally, now greatly decreased and below the base line, producing now excitement and now depression, as the case may be.

The constitutional factor would appear to be at work in organic conditions as well. The psychosis known as dementia paralytica (general paresis) is due to syphilis affecting particularly the frontal lobe. Yet the question still remains open why of a hundred cases of tertiary syphilis, a certain number develop paresis, another group develop tabes dorsalis, while still another group, instead of developing tertiary neurosyphilis, develop a totally different parenchymatous form.

Like considerations hold in the arteriosclerotic and other organic psychoses; clinical studies of such conditions supplemented by neuropathologic findings reveal that the clinical reaction appears to have no specific relation to the degree of pathology involved. There is little doubt that

a good deal depends upon the original psychologic and personality make-up of the individual, perhaps fully as much as upon the pathology present. Yet this leaves us totally in the dark as to what is back of all these factors.

It has long been known that sexual problems play a large role in the etiology and development of neuroses and psychoses, but little attention has been paid to the possible constitutional factors in the case. In this respect, one feels that there is a great deal of basic difference between neuroses and psychoses. In the instance of neuroses one is impressed with the original hypersexuality of the subject; it is as if these individuals are constitutionally endowed with a stronger sexuality which, because of it, asserts itself precociously and overflows into all sorts of channels, precocious attachment to members of the family, early masturbation, perversions, etc., something we do not find early in normal people. Because of such exuberance of expression, the environment finds it necessary to use much greater repressive force than it would need in the case of the normally developing child. Hence, the neurotic manifestation which expresses the individual's difficulty in adapting his basic needs to the demands of society.

In the functional psychoses, on the other hand, we have quite a different situation. In dementia praecox evidence points to the fact that the sex life of these individuals is meager from the beginning. Precociously, there may be a few scattered attempts here and there, but the effort soon dies out. For the most part, these individuals seem to be entirely inadequate to the demands of sex; and it is significant how many of them break down when confronted with an acute sexual situation; anxiety over masturbation, engagement, wedding night, birth of a child, etc. There is little physical expression in their sex life; even masturbation is meager. All of their sex life appears to be relegated to the realm of the mental, where it is concealed behind the symbolic fabric of delusions and hallucinations.

Even the manic-depressives, though these individuals are commonly credited with sexual exuberance, do not possess anywhere near the virility which is presumed to be a part of their make-up. In many respects their sex life is not unlike that of the praecox. In all too many instances we find a sexual conservatism that is sometimes expressed in complete abstinence, even asceticism.

In another situation the problem of constitution may well influence the whole of the individual's behavior, namely homosexuality. On the basis of actual bisexuality, which is a part of every one of us, it may well be assumed that the heterosexual and homosexual components exist in a certain fairly definite ratio. Should this ratio be somewhat modified morphologically, it may readily be seen what an undoubtedly strong influence this may have on the individual psychologic behavior. On the assumption that the normal ratio is, say, 85:15, should the ratio become 80:20 it would influence the individual's behavior toward the same and opposite sex. Here environment playing on the constitution may have considerable influence and determine just how this changed relationship will affect the individual's sexual behavior. One environment may be so well balanced as to be neutral or insignificant in terms of influencing the individual's sexual behavior, while another environment may so influence the individual toward homosexuality that, on reaching adulthood, he may well adopt this sexual pattern or be precipitated into a conflict.

With good reason the clinical psychiatrist always looks for such causes in the environment as may account for the symptoms present. The knowledge of these etiologic factors often helps him to adjust the patient on a superior level. Psychoanalysts especially have gone beyond the usual clinical interview and by a special methodology are able to unravel the more basic causes that seem to go to the very fundamentals of human behavior; ever so often, however, we seem to strike a snag. Here is a woman who has

led the most exemplary, even if rather uneventful life. The most careful study of her history fails to reveal even a suggestion of mental abnormality. In the words of the husband, their married life has been one of continuous romance. The menopause was normal. Then at the age of 50 and seemingly out of a clear sky, with absolutely nothing in the environment to explain it, she suddenly developed a most regressive involuntional psychosis from which it took her over a year to recover. As there does not seem to be anything in the environment to explain it, it appears to be entirely plausible to assume that there must have been, in such a case, a constitutional predisposition to psychosis. A few such cases have been psychoanalyzed, the material brought forth showing that the psychic etiology precedes even the Oedipus situation, what is known as the pregenital level. It is suggestive, however, that the deeper and farther we go into such etiology, the less environmental the material becomes until it is so vague and nebulous as to fuse with the constitutional, beyond which it seems impossible to go.

It is well now to say a few words about the psychologic bases as found in neuroses. One of the cardinal tenets in psychoanalysis is the universality in neuroses of the Oedipus complex. In active analytic treatment of patients, one comes sooner or later upon this complex. Not only is it there in most unequivocal terms, but its unearthing, attended by adequate emotional ventilation, brings relief from neurotic symptoms and a clinical improvement or recovery. Yet we are forever haunted here by the unanswerable query: why and wherefrom the Oedipus complex? Are the mothers of these psychoneurotics different from millions of other mothers in some special, qualitatively different way? Why should John Smith, who suffers clinically from a deep-seated psychoneurosis, become so markedly attached to his mother at the tender age of 3 years, that this attitude should remain with him throughout his 30 years of life, influencing and crippling his entire behavior? While of course

it is possible that something very intimate and subtle has transpired between infant John Smith and his mother, the more plausible explanation is that John Smith was constitutionally predisposed to need and absorb such tenderness as his mother gave him, perhaps demanding more of it than the average child.

Recently we have heard a great deal of the variety of psychogenetic situations that may be found in neuroses; in particular, overprotection in some cases, indifference and rejection in other cases, have been credited with the role of traumatic factors. There is little doubt that such factors exist, but one wonders whether it is the mother and the home situation that are responsible for the accentuation of normal maternal affection with pathologic overprotection or rejection, or whether the child by its behavior invited such exaggerated response on the part of the mother. Often enough in a family of many children, say 8 or 10, 1 child, occupying no striking ordinal position nor having gone through acute sickness that would demand excessive care, will develop an extreme neurosis, while the rest seem to have escaped unscathed. Is the problem with the mother or the child? Let us not rush into a hasty decision, yet it does look as if *Neurosen als Schicksal*, neuroses as fate.

The presumed reasons given for the development of neuroses are sometimes so tenuous as to appear ridiculous, making one wonder how they could act as significant traumatic factors. The neurosis of 1 of my patients seemed to center around the fact that he was born 8 months and 25 days after his parents' marriage. Around this fact he wove a complicated neurotic web. To him this meant that he was an illegitimate child, that his mother was a loose woman, his father profligate, perhaps not even his father, etc., all, of course, going back to the Oedipus situation. This raises the question of emotional lability, of the extreme sensitiveness of neurotics, of the unusually vivid imagination. Are all these factors a part of the original constitutional make-up, or were they normal but fostered and

driven into abnormal channels by a vicious environment?

In summing up, there has been no attempt here to make an extensive survey or go through the literature on the subject, but merely to give you one's reflections based on some 25 years of clinical experience. No doubt I have raised more questions than I could answer, but that is because I come to you more as a truth seeker than a trail-blazer, hoping more to receive than to give. I believe the problem is important and we need a more frequent meeting of minds. If my presentation has conveyed to you the impression that in my view constitution plays a large role in psychiatry, you are entirely right. At the same time, we can't escape the insight that the role of the environment is also of no mean significance. Just as it is often difficult to say where one ends and the other begins, so it would be difficult to say which is more important; one even wonders whether such a question need be raised; it is more of a pseudo-problem, as Dr. William A. White would say. The two apparently stand in inverse reciprocal relationship, or do they? Perhaps they stand for two plus factors in the same equation. One is not sure here whether the environment of today may not be the constitution of tomorrow. I have heard it said that structure is organized or crystallized function. This is a beautiful statement, but I don't know what it means. When and how is function converted into structure?

In the long run it is the behavior that is important, and for our purposes we may subsume under the term behavior not only the overt reactions of the individual in response to external stimulation, but even the working out of the innermost psychic processes in response to the infinite amount of internal stimulation; for every bit of behavior in turn becomes a stimulus for the next behavior. Is, then, this behavior the resultant of the interaction of two opposing factors streaming from different directions and meeting at one point of confluence where behavior results, or are we dealing here with a relatively simple additive process wherein the environment plays upon and with constitution, producing behavior? As yet we can offer no definite formulation.

Finally, even if it is to be accepted that constitution plays an exceptionally large role in the development of neuroses, it need not make us therapeutic nihilists, as is unfortunately the case with all too many psychiatrists. For if we can, through proper therapeutics, effect relief from environmental tension, and cure the illness, the constitution, for all its importance, may be made to recede into the background. If I may be permitted to borrow the terminology of genetics, effective psychotherapy can reduce constitution from a dominant to a recessive position and make the control of the environment dominant; and that, it seems to me, is no small accomplishment.

THE TREATMENT OF GONOCOCCAL VAGINITIS IN CHILDREN WITH PENICILLIN*

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7 HERE have been rapid advances in the treatment of gonococcal vaginitis during the past several years. However, as yet no form of treatment has been proved to be invariably successful. Therefore, since a new agent of high probable potency and low toxicity has been introduced, it is both practicable and germane to test this drug in patients with this infection. Penicillin is such an agent. Its efficacy against gonococcal infections in adult males was first demonstrated by Herrell, Cook and Thompson,¹ and in females by Cohn, Studdiford and Grunstein.² The latter authors treated 1 child with gonococcal vaginitis successfully with penicillin, and Greenblatt and Street³ reported 3 children in their group of female patients with chemoresistant gonorrhea who responded well to penicillin.

Since April 1, 1944 we have been able to treat 17 young patients with gonococcal infections with the sodium salt of penicillin. Our purpose in this report is to describe our experiences in the treatment of these patients.

MATERIAL

Between April 1 and December 31, 1944 we have used the sodium salt of penicillin in the treatment of 15 children with gonococcal vaginitis, 1 with both vaginitis and conjunctivitis, and 1 with conjunctivitis. All the patients were

treated on the Pediatric Ward of the Gallinger Municipal Hospital. The diagnosis in 16 patients was established by culture, that is, by obtaining "dye positive" colonies of gram negative biscuit-shaped diplococci from vaginal or conjunctival secretions when cultured on chocolate agar under increased carbon-dioxide tension. Multiple cultures were obtained in 13 patients, single cultures in 3. Cultures were positive within 48 hours of treatment in 14 patients. Two patients had positive cultures in the clinic 1 week before admission. The clinical condition was unchanged, and stained films of the vaginal discharge showed typical gram negative diplococci, but repeat cultures were negative on the day treatment was started. In the case of 1 patient with vaginitis and conjunctivitis both the clinical picture and the smears were typical, but cultures were negative. Because of the severity of the eye infection treatment was instituted immediately and further cultures were impossible.

Our method of obtaining vaginal cultures is practicable and nontraumatic. Glass tubes 6 inches long and 5 mm. in diameter are annealed with heat to round the edges. They are sterilized, fitted with a small rubber bulb, and filled for a distance of 2 cm. with warm sterile water. The water acts as a lubricant and allows the tube to be inserted into the vagina without trauma, and to be passed into the vault. Gentle pressure on the bulb washes the vaginal vault and its release draws the washings into the tube. A drop of the vaginal washing is placed

* From the Department of Pediatrics and the George Washington University Medical Division, Gallinger Municipal Hospital, and the Food and Drug Administration, Federal Security Agency.

on a chocolate agar plate, after which it is spread with a sterile cotton-tipped applicator.

All patients were hospitalized for 4 to 7 days after treatment. Cultures were taken frequently during this time. The patients were then discharged and were followed in the clinic at weekly intervals for 1 month, then at intervals of 3 or 4 weeks for another 2 months. No patient was discharged as cured until she had been followed for 3 months.

varied from 12 to 27 hours. Ten patients were followed until they were discharged as cured; 3 refused to return to the clinic but had 3 to 5 negative cultures before leaving the hospital. They probably were cured, although the exact results are uncertain. One patient, a Negro aged 10, who had had a gonococcal vaginitis in 1940 that cleared after prolonged treatment with intravaginal estrogen, was treated with 10,000 units of penicillin every 3 hours for 5

TABLE 1

CASE NO.	RACE	AGE	CULTURES BEFORE TREATMENT	TREATMENT—PENICILLIN			CULTURES AFTER TREATMENT		REMARKS
				Individual dose*	Frequency by hours	Total dose*	No. neg.	Days neg.	
		years							
1	N	5	3 positive	10	3	80	9	98	Cured
2	N	11	1 positive	10	3	70	9	111	Cured
3	N	5	3 positive	10	3	70	9	91	Cured
4	N	10	3 positive	10	3	70	9	91	Cured
5	W	6	2 positive	10	2	100	3	4	No clinic visits
6	N	4	2 positive	10	2	100	5	7	No clinic visits
7	N	9	2 positive	20	3	100	7	90	Cured
8	N	7	1 positive	20	3	100	9	102	Cured
9	N	9	Negative**	10	3	100	11	188	Conjunctivitis and vaginitis both cured
10	N	2	2 positive	10	2	50	11	108	Cured
11	N	2	3 positive	10	3	50	12	129	Cured
12	N	3	2 positive	10	3	50	3	5	No clinic visits
13	N	10	1 positive	10	3	50	2	2	Relapse—3rd day
				10	3	100	6	20	Relapse or reinfection after 20 days
				25	2	350	13	137	Cured
14	N	7	2 positive	50	1 dose	50	0	0	Failure
				25	3	125	11	98	Cured
15	N	2	1 positive	50	1 dose	50	3	13	Relapse when next seen on 61st day
16	N	4	2 positive	50	1 dose	50	3	4	Relapse on 5th day
17	N	1½	4 positive	5	3	50	2	7	Conjunctivitis cured

* Expressed in thousands of Oxford units.

** Smear showed typical gram negative intracellular diplococci in the discharge from both the eye and vagina.

RESULTS

The details of treatment are presented in table 1. Twelve patients with vaginitis, 1 with vaginitis and conjunctivitis, and 1 with conjunctivitis were treated with multiple injections. The individual dose varied from 5,000 to 20,000 units, and the length of treatment

doses. Two cultures were negative, but the third was positive. She had a second course of 10,000 units of penicillin every 3 hours for 10 doses. She had 4 negative cultures in the hospital, and 2 in the clinic. Three weeks after discharge she returned to the clinic with either a recurrence or a reinfection. It was feared that

she might be developing a penicillin-resistant strain of gonococcus. Therefore, her third course of penicillin was 25,000 units every 2 hours for 14 doses, a total of 350,000 units over 26 hours. She was followed for 137 days, during which 13 cultures were found to be negative before she was discharged as cured.

Welch, Putnam, Randall and Herwick⁴ have recently reported that a single dose of 25,000 units of the sodium salt of penicillin cured 37 among 58 adult patients with gonorrhea. This suggested that a single large dose of regular penicillin might be adequate for the treatment of children. Consequently 3 patients were each given a single dose of 50,000 units intramuscularly. All 3 children so treated failed to respond, although transient negative cultures were obtained. One patient subsequently received 25,000 units of penicillin every 3 hours for 5 doses. She has been followed for 98 days, with 11 negative cultures. The remaining 2 children have had other therapy.

COMMENT

Penicillin has been found to be very effective in the treatment of gonococcal vaginitis in young children when given in multiple injections over a period of 12 hours or more. The exact schedule of dosage remains to be determined. Our only

failure was with a large child of 10 years who received only 50,000 units over 12 hours. She responded well to larger doses although it is uncertain whether her second recurrence was a relapse or reinfection. It is our belief that children of 7 years or under probably will respond to a dose of 50,000 units given over 12 hours, while older patients should be given approximately 100,000 units of penicillin. A single large dose of regular sodium penicillin is not effective, although it is possible that 2 or 3 injections of 25,000 to 50,000 units each at intervals of 2 or 3 hours may be curative. This regimen will be investigated, since, if satisfactory, it would greatly simplify the office or clinic treatment of such patients.

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THE ALLERGIC NOSE

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THE most commonly overlooked and mismanaged symptom-complex today is that of the allergic nose. A disease that does not cause much pain or distress, and is usually without fever, is frequently ignored by the patient. When the inconvenience becomes annoying, he consults a physician. After weeks, months, and often years of local treatment the patient begins to wonder why he still has his original symptoms. He discovers from a lay friend, who has had the same symptoms, that perhaps his nasal difficulty is of allergic origin. Perhaps the frequent colds, sinus infections and "throat irritations" are really due to what he eats and breathes instead of the result of germs. When the original symptoms persist in a child who has had his tonsils and adenoids removed, the parents begin to wonder whether the operation was at all necessary.

Symptoms of nasal allergy are usually associated with other allergic diseases such as hay fever, asthma, urticaria, eczema, migraine, gastrointestinal disturbances, etc. With the present interest in the subject and the increasing knowledge of allergy, diagnosis and treatment of allergic diseases should become more effective in the future.

Common terms for these symptoms are chronic catarrh, chronic sinusitis, atopic coryza, atopic rhinitis, perennial allergic rhinitis, perennial hay fever, nasal allergy, seasonal hay fever, pollinosis, and nasal asthma.

Hansel¹ has published interesting statistics revealing the incidence of allergic disease in his own otorhinolaryngologic practice: 35 per cent of patients in routine office practice had allergic disease, 44 per cent with nasal complications were allergic, 27 per cent with nasal allergy had

hay fever (seasonal), 80 per cent with seasonal hay fever had other sensitivities than pollen and other manifestations of allergy, 40 per cent of the general population have minor allergy, and 15 per cent of the population have major allergy.

The pathogenesis of allergy becomes apparent to the pediatrician who is in a position to study his patient from birth. Its growth and development are seen in the infant with eczema, persistent colic and vomiting. From 80 to 90 per cent will show these first symptoms before they are 1 year of age. This progresses into other forms of allergy, such as frequent coughs and colds, the beginning of the allergic nose. Hay fever, asthma, urticaria, etc., may also occur. Eczema frequently disappears spontaneously at about 18 months of age only to reappear in another form of allergy, usually nasal, and often associated with asthma. The infant or child with early allergy is the potential patient with major allergic disturbances as he grows older. Few individuals develop nasal allergy or asthma who have not had a previous history or some earlier allergic manifestations.

PATHOLOGY

The pathology of allergy is edema and eosinophilic infiltration of the tissue which is involved, whether in the nose, bronchial tubes, skin or gastrointestinal tract. The eosinophils migrate through the epithelium and are found in the secretions. Nasal and sinus secretions, therefore, may be valuable as diagnostic aids. The cytology of these secretions may be an index of the pathologic process in the tissues. Polyps are usually an indication of underlying allergy.

SYMPTOMS

Symptoms of the allergic nose resemble hay fever and have the same basic mechanism. They are usually milder, do not affect the eyes, and occur during any season. In most instances the symptoms are as classic as those occurring in other diseases. The adult patient complains of nasal distress, often of years' duration. His nose is "stuffy" usually every night while in bed and on arising in the morning. This is the one cardinal symptom. He usually states that in an hour or two after arising his nose becomes clear so that he can breathe freely through both nostrils. During the day the nasal passages are usually open, although there may be occasional stuffiness.

His nasal distress begins when he retires at night. Within a short time one nostril becomes congested, usually on the side on which he happens to be lying. This obstruction may last for a few minutes or all night. On changing from side to side, the nasal stuffiness tends to alternate from one nostril to the other. Usually only one side is closed at a time, although both may become obstructed. Frequently the patient awakens with a dry mouth as a result of mouth breathing. A bad taste as well as a foul odor emanating from the mouth may be present. On arising he rasps, hacks and clears his throat, spitting out varying amounts of thick gray mucus. The nose is blown frequently without much result. The patient often has a dull feeling or a headache. Fatigue is often more noticeable in the morning than at the end of a day's work. The fact that the nasal symptoms are transient is ample evidence that there is no nasal obstruction due to a bony growth, a broken nose, enlarged turbinates or a deviated septum. In other words, symptoms that are obstructive at one time, and then become entirely relieved without treatment at other times, are sufficient evidence to indicate that operative treatment is definitely contraindicated. This perhaps explains the majority of failures in nasal and sinus surgery.

Headaches are frequently associated with the disturbance. So-called chronic "vacuum headaches," migraine, bilious spells and sinus headaches, often occurring behind one eye, on one side of the head, or in the occiput, are usually part of an allergic condition. In these cases the clinician usually discovers mild nasal symptoms which direct his attention to the associated and underlying allergic origin. Deafness, often becoming permanent, may be due to nasal allergy involving the Eustachian tubes or to constant, improper and forceful blowing of the nose. Chronic fatigue and general malaise occur with the above symptoms. Other forms of allergy may be present as well.

Seasonal nasal allergy or plain old-fashioned hay fever is well recognized. The symptoms are manifested during the pollinating seasons of the trees, grasses or weeds, depending upon the geographic location and the season of the year. Patients with the perennial type of nasal allergy, who also have seasonal hay fever, usually have more marked symptoms during the pollinating seasons. In young children these symptoms are characterized by frequent coughs and colds. They no sooner get over one cold than they "come down" with another cold. The nose is always running and is usually stuffy. Cough is common, especially at night and early morning. Fever is usually absent. These so-called colds usually take a long time to clear up.

In a great majority of the cases the history states that the patient has had many and varied treatments. The common story in children is that they have had tonsil and adenoid operations, cold "shots" or pills, quartz lamp treatments, often for years, nose and sinus operations, shortwave and various electric treatments. Nevertheless, they return to the physician with the same complaints and symptoms.

The history is of vital importance inasmuch as the examination may be entirely negative. In the physical examination only about 50 per cent with allergic nasal disease will show the characteristic edema and pallor of the mucous mem-

brane at the time of the examination. Therefore, the diagnosis cannot always be made solely on the local findings. The patient is asked to blow each nostril separately to note any obstruction, or a breathplate mirror may reveal the alternating stenosis.

DIAGNOSIS

The diagnosis of nasal allergy is similar in every respect to that of other allergic conditions. Chronicity and periodicity of the symptoms, plus the fact that all previous treatment has been of no avail, should immediately suggest an allergic basis for the symptoms. Too great an emphasis cannot be placed upon the importance of repeated examinations of the patient and his nasal secretions before disproving the presence of allergy. Nasal smears will almost invariably show a predominance of eosinophils in allergic nasal conditions. It may be necessary to examine several smears to confirm the diagnosis.

Roentgen film findings of the nose and sinuses in allergic individuals have been quite misleading and misinterpreted until recent years. Positive sinus findings are the rule rather than the exception, due to edema of the sinus mucosa similar to that of the nasal edema. Infection of the sinus is not as common a complication of respiratory allergy as is generally believed.

Foods as a cause of nasal stuffiness are much less important than inhalant factors. They are more of a factor in infants and young children. After the age of 3 or 4 years inhalant factors become predominant. Nasal symptoms due to foods are always more prominent during the daytime when the patient eats his food. The patient who is bothered more during the night and early morning is sensitive to allergens which he inhales. The bedroom atmosphere contains dust which has many minute particles from feathers in pillows, kapok, hair or cotton in the mattress, wool from rugs, and blankets, clothes, drapes, pictures, trophies, especially animals, powders, shampoos, perfumes, sprays, smoke, pets, shaving lotions, pollens, molds, etc., any or

all of which may be factors irritating the nasal mucosa.

TREATMENT

Treatment of allergic disease as in other chronic constitutional ailments is often a matter of months and years. As with the diabetic and tuberculous patient, it is necessary to plan a régime covering the actions of the individual over a period of years. Too many failures have resulted from those who expect to be cured by eliminating a food, or a feather pillow, or by expecting results within a very short while. The patient must understand that the allergic study is just another diagnostic test, not a treatment. Treatment is directed and governed by results of the testing. However, 75 to 90 per cent of these patients can be given satisfactory relief with proper allergic treatment. Specific treatment may consist of one or all of the following routine:

Diet.—Correction of the diet is made by eliminating the foods found positive on testing, or by clinical experience. Elimination diets are often of value. Milk, wheat and eggs are the most common offending foods. A small amount of an offending food may be just as bothersome as a larger amount.

Environmental Control.—Avoidance of specific allergens and the preparation of a dust-free room are of paramount importance. The following specific directions are given for a dust (allergen)-free bedroom, in order to minimize the dust content of the air.

1. The patient's bedroom should contain only the necessary furniture, such as bed, dresser, table and chair.

2. No rugs, curtains, doilies or cloth decorations should be used unless they can be washed weekly.

3. The walls should be painted (washable), if possible.

4. All woodwork and furniture should be washed once weekly.

5. Furniture and floors should be oil-mopped daily and vacuum-cleaned only.

6. All books, fuzzy toys and clothes are to be kept in another room or in a clothes closet which is dustproofed.

7. Kapok or cotton pillows may be necessary; feather pillows may be used if covered with allergen-proof materials.

8. The mattress should also be covered completely, as it is probably the best dust-catcher in the room. Down or feather pillows used in the mattresses in bassinets are responsible for many cases of eczema and asthma in babies. Wool blankets may be covered with a bag made of sheets. Silk should be avoided.

9. Avoidance of all animals (pets), plants, smoke, flowers, powders or dust in the immediate environment is necessary. The patient is not to play in basements, attics, garages, empty lots or other dusty places. Insecticides should not be used. Windows should be closed or cheese cloth used to screen any open portion.

It is surprising to note the great amount of relief obtained by these measures. With proper coöperation no further treatment may be necessary. When the desired effect has not been attained, it is necessary to rely upon specific desensitization.

Specific desensitization with antigens made from pollens, molds, epidermals or dust is effective in 60 to 70 per cent of cases. This is of great importance, since the inhalant factors are in the dust in the air of the bedroom as well as other rooms. Medication is of very little value other than nose drops such as isotonic aqueous

shrinking preparations, which give symptomatic relief.

Although there are definite indications for tonsillectomy in many patients with respiratory allergy, the operation should not be performed primarily for relief of allergic symptoms. Indications should be the same as in any nose and throat case without nasal allergy. If tonsillectomy must be performed, it will not materially influence the allergic symptoms. Nose and throat surgery should be avoided during the pollen hay fever season, especially in children. This will often prevent an exaggeration of the allergic symptoms.

Occasionally surgical procedures afford some relief. In any eventuality, however, operations on the nose should be performed only after proper treatment of the allergic state. Even then, such a measure should be resorted to only after a consultation with a competent allergist, and an ear, eye, nose and throat specialist.

SUMMARY

The allergic nose is a common entity. Symptoms are primarily those of chronic nasal obstruction occurring more frequently during the night and the first thing in the morning. Recognition of the allergic survey will usually furnish sufficient information to make available adequate treatment, which is usually effective.

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UNUSUAL CASE OF DISSECTING ANEURYSM OF THE AORTA

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HEREIN is recorded an atypical case of dissecting aneurysm of the aorta. Clinically and electrocardiographically this case simulated coronary thrombosis. For the purpose of increasing awareness of dissecting aneurysm a typical case is presented. This typical case has been built up from 14 correctly diagnosed cases reported in the literature.

Dissecting aneurysm of the aorta has been recognized as a clinical entity for over 200 years. It was first described in 1728 by Nicholls¹ at autopsy for King George II of England. From that time until 1934 Shennahan² found only 6 correct ante-mortem diagnoses in 300 reported cases. In recent years very little change has taken place in clinical consciousness of this disease state. As a result there has been no change in therapeutics. Tufnell's treatment in 1885 consisted of bed rest, use of a low calory diet, abstention from liquids, and the administration of potassium iodide by mouth.

Pathologically, the basis for the dissection may be coarctation of the aorta in young adults,³ trauma,⁴ and the stress of labor. Syphilis is unimportant as a cause of dissecting aneurysm of the aorta. Kellogg and Heald⁵ have very nicely worked out the pathology of this condition. They found a primary sclerosis of the vasa vasorum of the aorta with secondary nutritional changes in the media. These changes consisted of fragmentation, thinning, disorder and reduction of the number of the elastic lamellae in the media. Hyaline degeneration and atrophy of the smooth muscle elements are also present. These changes render the media

easily separable and favor dissection after intimal tearing has taken place.

DIAGNOSIS

Table 1 contains briefly the essential clinical histories of 15 cases of dissecting aneurysm of the aorta diagnosed during life. A history of hypertension was elicited in 13 cases; 14 of the patients were of the male sex; the average age for the group was 50 years; sudden agonizing pain, maximal at the onset, occurred in 14 cases; dyspnea was present in only 3 cases; location of the initial pain was in the region of the anterior or posterior thorax in 9 cases, in the abdominal region in 3 cases, at the base of the neck in 2 cases, and at the back of the right shoulder in 1 case; radiation of the pain to regions below the level of the diaphragm occurred in 9 cases, whereas there was no radiation in 4 cases; during the acute episode the blood pressure was elevated in 12 cases, and in 1 case it was not recorded but a large heart was described which probably represented hypertensive heart disease; peripheral vascular occlusion was manifest in 9 cases; exertion preceding the onset occurred in 7 cases; a diastolic basal murmur was present in 5 cases; the electrocardiogram in 11 cases showed non-specific changes in 8 cases, transient left bundle-branch block in 1 case, and changes suggestive of posterior occlusion in 2 cases; roentgenograms of the chest were made in 6 cases, and changes were noted that led to the diagnosis in 5 cases. The Wassermann reaction was positive in 2 instances, but the aortic changes were not those of luetic aortitis.

TABLE 1
Pertinent Data of Reported Cases of Dissecting Aneurysm

BIBLIOGRAPHY REFERENCE NO.	3	7	8	10	13	14	15	16	17	18	19
Sex, age	Male, 52	Male, 75	Males, 41, 39 Female, 32	Males, 44, 57	Male, 48	Male, 55	Male, 51	Male, 63	Male, 61	Males, 34, 61	Male, 65
Onset	Sudden with collapse	Sudden	Sudden	Sudden	Sudden	Sudden	Sudden	Sudden	Sudden	Sudden	Unconsciousness and convulsion; 3 minutes later awoke with severe pain and paresis of left leg, shock
Pain	Severe, maximal at onset but coming on 4 hours after onset	Severe, maximal at onset	Severe, maximal at onset	Severe, maximal at onset	Severe, maximal at onset	Severe, maximal at onset	Severe, maximal at onset	Severe, maximal at onset	Severe, maximal at onset	Severe, maximal at onset	Severe, maximal at onset
Location	Precordium and upper back	Back of neck and upper dorsal region	Substernal in 2 cases; base of neck in 1 case	Substernal in 1 case; right shoulder in 1 case	Abdomen	Precordium and spine at the same level	Thorax extending from nipple to region of umbilicus	Epigastrium	R.L.Q. of abdomen	Retrosternal in 1 case; interscapular in 1 case	Retrosternal
Radiation	Pain in back encircled chest	Down back to substernal area	Legs in 2 cases; R.L.Q. of abdomen in 1 case	Abdomen in 1 case; thighs in 1 case	Coccyx	None	To region of umbilicus	Epigastrium	To xiphoid process and base of neck	Abdomen in 1 case; left leg in 1 case	None
Dyspnea	No	No	In 1 case	None	Yes	None	None	None	None	In 1 case	No
History of exertion	No	No	In 3 cases	In 2 cases	Yes	No	Yes	None	None	None	No
Hypertension	Yes	Yes	In 3 cases	In 2 cases	Yes	Yes	Probably large heart on physical 1 year before illness	No	Yes	In 1 case	No
Initial blood pressure	200/100 (rt. arm), 100/60 (left arm)	165/140 (rt. arm), 180/140 (left arm)	High in 3 cases	High in 2 cases	150/90	180/?	Not recorded	212/118	Low	High in 1 case; low in 1 case	180/?
Peripheral vascular occlusion	Yes	No	In 2 cases	In 1 case	Yes, appearing late in the illness	None	Present	None	Yes	In 1 case	Present
Cardiac murmurs	No	No	Aortic diastolic in 2 cases	Aortic diastolic in 1 case	No	None	Diastolic at base	None	None	Aortic diastolic in 1 case	None
E.C.G.	Not done	Nonspecific	Transient left bundle-branch block in 1 case	Suggestion of posterior occlusion in 1 case	Nonspecific	Not done	Not done	Not done	Incomplete bundle-branch block	Nonspecific changes	Not done
Wassermann reaction	Not done	Not done	Positive in 1 case	Negative	Not done	Not done	Not done	Negative	Not done	Positive in 1 case; no luetic aortitis in either case at post	Not done
X-ray film of chest	Not done	Diagnostic changes	Not done in 2 cases; diagnostic in 1	None taken	Diagnostic changes	Diagnostic	Not done	Diagnostic	None taken	Negative in 1 case; not done in other case	Not done

A typical case of dissecting aneurysm of the aorta might be constructed from the above analysis of cases as follows: The patient would be a known hypertensive male of about 50 years of age and would complain of sudden severe pain maximal at the onset in the region of the thorax; dyspnea and the sense of constriction seen so commonly in the coronary thrombosis would be lacking; the blood pressure would be maintained at a high level even in the acute episode and with symptoms of shock*; radiation of the pain to regions below the level of the diaphragm would be present; peripheral vascular embarrassment might constitute an important finding; absence of changes suggestive of acute coronary artery occlusion in the electrocardiogram would usually be noted and the roentgenogram of the chest might show progressive changes in the configuration of the aorta.

Because the patient is usually too ill to be moved an X-ray film of the chest is seldom taken. However, the information that can be derived from a chest plate warrants having it done if the condition of the patient is not too serious. Wood, Pendergrass and Ostrum⁶ describe roentgenologic features in 11 cases. They describe as a most pathognomonic feature shadows produced by dissection along 1 or more of the large branches of the aortic arch. A sign of lesser diagnostic value but of more frequent occurrence is the finding of an arcuate excrescence on the aortic arch or a widening of the supracardiac shadow. They stated that left pleural effusion commonly occurs, and if found to be blood on thoracentesis is diagnostic in the light of the clinical picture. Roesler, Gifford and Betts⁷ pointed out that if an "aneurysm involves only a part of the circumference of the aortic vessel and has a lateral location it will be visualized as an outer lighter shadow." When possible, therefore, it is desirable to obtain oblique and lateral as well as sagittal projections.

* One must not place too much emphasis on this point, since there is sometimes a fall of blood pressure, sometimes to an almost imperceptible point.—Ed.

The electrocardiogram as an aid in diagnosis is used to eliminate the possibility of coronary artery thrombosis when chest pain is an outstanding part of the clinical picture. An insufficiency of case reports with electrocardiographic data makes it impossible to state whether or not there are any changes specific for dissecting aneurysm. McGeachy and Paullin⁸ in 1937 reviewed 127 cases, and in only 15 had tracings been taken. The changes found in these tracings were not those of a coronary artery occlusion. One of their own cases showed transient left bundle-branch block.

However, findings suggestive of coronary artery thrombosis have been described. Osgood, Gourley and Baker⁹ report a case with progressive inversion of the T waves and R-T segments in leads I and II with elevation of the R-T in lead III. Glendy, Castleman and White¹⁰ report a tracing showing T wave changes in leads II and III suggestive of posterior occlusion. The right coronary ostium was compressed by the dissection in this case.

In contrast to the typical clinical picture of dissecting aneurysm of the aorta is the case for presentation. However, it only presents one of the diverse patterns which may be produced by dissection of the aorta. References 3, 8, 10 and 13 present numerous case histories in detail and are excellent for acquainting one with various manifestations of aneurysm of the aorta.

REPORT OF CASE

CLINICAL COURSE.—Mr. W. E., a white man aged 68, was admitted to George Washington University Hospital on July 30 and died on August 4, 1944. He was suddenly seized with a sharp pain in the region of the right maxilla which was momentary and reappeared seconds later at the lower part of the sternum. The pain cut off the patient's breath and was characterized as sharp. There was no radiation. This attack came while the patient was sitting on the edge of his bed. Weakness and cold perspiration were noted. The patient tried to go to the lavatory and fainted on the way. I saw the patient about 1½ hours later. He was slightly cyanotic, cold and clammy but mentally alert. His pain was still present but greatly diminished.

The patient had known he had hypertension for between 20 and 30 years. He had a systolic pressure as high as 240 mm. Hg. The family history and past history were otherwise essentially negative.

On initial examination the blood pressure in the right arm was 80/60, the pulse rate was 110, and the temperature was 96°F. rectally. There were a few moist râles in the right base posteriorly. The apex beat was slightly beyond the midclavicular line. A soft blowing systolic murmur was heard at the apex but was not referred to the axilla. The sounds were of poor quality. A2 was greater than P2. The radial arteries were tortuous and

and no more such episodes ensued. On August 2 the patient experienced some mild retrosternal pain lasting 10 to 15 minutes and not recurring. He improved clinically and felt stronger. The heart sounds became stronger. On August 4, 1944 he suddenly sat up in bed, clutched his arms as if in great pain, and quickly became unconscious. Metrazol, 3 c.c., was given intravenously by the resident, and artificial respiration was instituted. However, the patient's pulse became progressively weaker, and at 5:56 p.m. he died.

Therapy consisted of a salt-poor diet, restriction of fluids to 2,000 c.c. per day, the injection of atropine sulfate, grain $\frac{1}{100}$ (0.65 mg.) 4 times daily; absolute bed rest, and sedation with chloral hydrate.

On admission the white blood cells numbered 10,700 per cu. mm. of blood with normal differential percentages. The urine had a specific gravity of 1.025, contained 3 plus albumin, and revealed a few hyaline and granular casts, and a few erythrocytes and leukocytes. An electrocardiogram made on July 30 showed left ventricular preponderance and one on August 2 left bundle-branch block (fig. 1).

POSTMORTEM FINDINGS.—The heart was greatly enlarged; it weighed 700 grams. The epicardial surface was roughened by old fibrous adhesions. A blood clot was present in the anterior portion of the sac and was partially organized. The valves were all normal. One cm. above the commissures of the aortic valve there was a transverse linear slit 3 cm. long, almost encircling the entire vessel. The slit led into a channel in the wall of the aorta that extended downward for a short distance into the sinuses of Valsalva and distally throughout the thoracic aorta. Proximally the false sac lay close to the ostium of both right and left coronary arteries but did not appear to compress these structures. No dissection along the course of the coronary arteries was present, but there was clotted blood in the pericardial sac immediately adjacent to the left coronary artery and firmly bound to this vessel by pericardial adhesions. The dissecting sac extended into the arch of the aorta along the convexity, and a definite dissection extended up into the innominate artery as far as that vessel was exposed (fig. 2). This dissection almost completely closed off the true orifice of the artery, and the false sac was filled with partially organized thrombus; a narrow crescentic dissection extended upward along the left common carotid artery. No dissection was noted in the left subclavian. The intima of the aorta showed numerous atherosclerotic plaques, some of which were ulcerated and others calcified. The intimal tear in the ascending aorta is not in an area of atherosclerosis, however.

Microscopic examination agreed with the findings enumerated grossly.

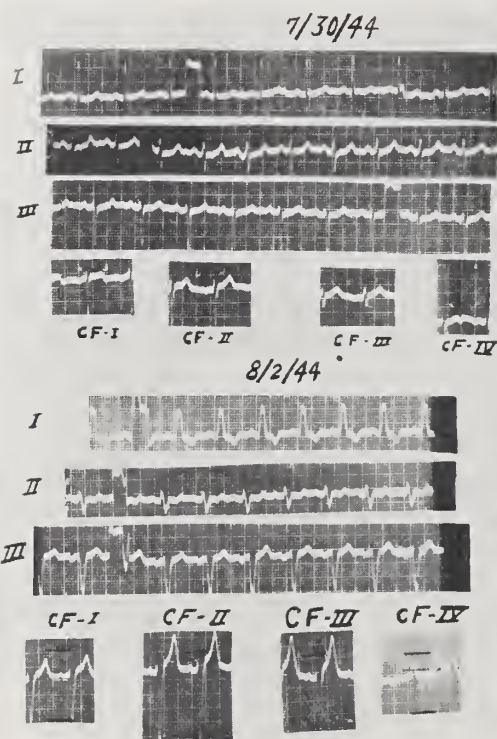


FIG. 1

nodular. The liver extended 2 fingerbreadths below the costal margin and was smooth and tender. Rectal examination revealed a smooth, moderately hypertrophic prostate. The patient was given morphine sulfate, grain $\frac{1}{4}$ (0.016 Gm.) and atropine sulfate, grain $\frac{1}{100}$ (0.65 mg.) and was sent to the hospital.

On admission the temperature was 101.8°F. rectally. The pulse rate was 110 per minute. Both gradually fell to normal on August 4, the last day of life. The blood pressure varied from 130/100 to 150/100. On August 1 in the early morning the patient became irrational and wandered all over the ward. Nembutal was discontinued

COMMENT

This very atypical case presented a clinical picture strongly suggesting coronary thrombosis. In retrospect certain symptoms pointed to the underlying pathology of dissecting aneurysm. The occurrence of sudden severe pain maximal at onset in the region of the thorax in a hypertensive patient should always suggest the need of ruling out a dissection. This was clouded, however, by a marked drop in blood pressure, dyspnea, cyanosis and location of the pain, all of which suggested the occurrence of an infarction. With the appearance of left bundle-branch block

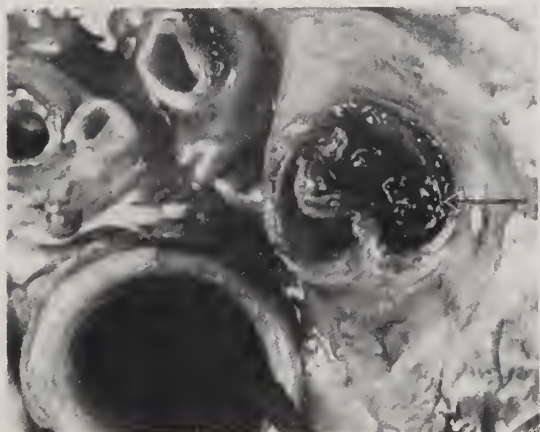


FIG. 2. Cross section of the aorta and pulmonary artery showing section with blood clot bulging into lumen of aorta.

in the electrocardiogram the diagnosis of infarction seemed tenable. Wilson¹¹ has shown that the patterns of coronary occlusion may be obscured in limb and precordial leads in presence of left bundle-branch block. However, if an X-ray film of the chest had been made the dissection of the left common carotid and innominate arteries would surely have been seen as a widening of the upper mediastinum or as shadows along these vessels and would have been most helpful.

From the beginning of the case the blood pressure was taken only in the right arm, and it is possible that at the onset the blood pressure might have been maintained in the left arm.

Palpation of all accessible peripheral arteries

done daily and systematically might have revealed diminution of right carotid and radial pulsations in view of almost complete occlusion of the innominate artery.

CONCLUSIONS

It is my belief that in all cases of clinical coronary thrombosis occurring particularly in hypertensives dissecting aneurysm must be ruled out. Possibly if more autopsies were done many a supposed coronary artery occlusion would prove to be a dissection of the aorta. This case demonstrates that dissecting aneurysm may simulate myocardial infarction. To rule it out one needs to exploit the use of X-ray films much more than has been done; he must be more systematic in palpating accessible peripheral arteries and making of blood pressure determinations on the extremities; the use of electrocardiography must become more universal, and its value in diagnosis will be determined by so doing; finally, it behooves us as clinicians to more thoroughly familiarize ourselves with the typical case and the very atypical manifestations which may be encountered with the eventual hope for some therapeutic agent where none has existed.

Dissecting aneurysm of the aorta is not always an immediately fatal condition. Osler¹² cites 1 case with survival for 30 years.

I believe that therapy should be more pointedly directed at lowering of the blood pressure during the acute phase. This could be accomplished in the fashion of the depressor test with maximal doses of sodium amytal. The resultant lessening of strain on the media might stop dissection and allow thrombosis to take place and life to be prolonged.

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President's Page

CARRYING ON FOR THE PRESIDENT

As your President informed you in the last *MEDICAL ANNALS*, he is now overseas. Those of us who worked with him during the months he was actively the head of this organization appreciate what a splendid Society official he was and how much the Society missed not having him on a full-time basis. For few men have better judgment and greater capacity for making friends than "Jim" Greear. We sincerely hope that he will return to us before too long.

The Society's Constitution and By-laws provides that "the Vice Presidents shall, in order of their rank, assume the duties of the President during his absence or inability to act." In accordance with this provision, I have become your Acting President. I trust that I will enjoy the confidence which members of the Society repose in their President. For my own part, I will give the best I have to my new task.

You may recall that a year or so ago the Society voted that the First Vice President should be invited to attend meetings of the Executive Board. The thought behind this move was that should the elected President, for one reason or another, be unable to perform his duties, the First Vice President would be prepared to take over for him. The far-sightedness of this decision is shown by what has occurred.

Fortunately, I have been present at many Board meetings and have an idea of the scope of the Society's program, which, I may say, is beyond what is generally realized by the membership. I wish all our members had full knowledge of what is being done for the profession and for the people of the community by our Society. They would not only be pleasantly surprised but would feel a deeper sense of loyalty to their organization. As it is, the Society has received fine support from nearly every quarter. And this is exceedingly important, for it is all too apparent that our strength as an organization will be severely tested in the days ahead.

Which reminds me that one of the interesting and worthwhile projects of the Society is the correspondence being carried on by the Secretary with our physicians in the armed forces. In his last letter the Secretary, upon the request of the Committee on Service Physicians, asked the following questions:

1. Do you intend to return to medical practice in Washington?
2. Have you an office in mind or would you like the Society's help in finding one?
3. Do you plan to take advantage of the educational benefits to which you are entitled under the recently enacted G. I. Bill?
4. Are you interested in clinic practice—that is, would you like to do group practice upon your return? If so, would you feel that the Society could be of help in this regard by providing you with information about private clinics now in existence?
5. What are your views in regard to the Society sponsoring a prepaid medical service plan?

Many answers have been received and they are most illuminating. The thing that stands out above everything else is the fact that there is no doubt in the minds of our service physicians that changes are going to take place in medicine and they are anxious that the Society sponsor a forward-looking program.

If any of you have any matters you wish discussed on this page during my incumbency, give me a ring. I will appreciate hearing from you.

Wm. M. Ballinger

ACTING PRESIDENT

Seventh
War Loan
Drive.....
begins
April 9, 1945

Make your war bond purchases NOW!

Editorials

THERAPEUTIC INDICATIONS FOR PENICILLIN AND THE SULFONAMIDES

Any new therapeutic agent which gives a fair promise of success will receive its initial trial at the hands of the medical profession to the accompaniment of much enthusiasm. This has been especially true of penicillin, partly because of the ballyhoo with which it was greeted by the lay press and partly because of that peculiar quirk of human nature which makes us want to try something that is difficult to get. Now that penicillin has become available through the usual commercial channels, it behooves us to reëxamine its status and determine in just what diseases it should be used. Furthermore, we should know when to use penicillin alone, when to use it in combination with the sulfonamides, and when to use the sulfonamides alone.

At the present time, the evidence seems clear that penicillin is beneficial, when used alone, in the following conditions:

- Anthrax
- Empyema
- Endocarditis
- Gas Gangrene?
- Gonococcal Infections
- Leptospirosis
- Relapsing Fever
- Staphylococcal Infections
- Syphilis

Some investigators suggest, however, that better results may be obtained in the severer staphylococcal infections when sulfonamides are added to penicillin.

The combination of penicillin and sulfadiazine or sulfamerazine in the treatment of pneumococcal meningitis is superior to the use of either agent alone. Whether this is true for any other diseases has not yet been determined.

At the present time, it seems best to use sulfonamides first in the following diseases, reserving penicillin for use if the results with the sulfonamides are not satisfactory:

- Actinomycosis
- Meningococcal Infections
- Pneumococcal Pneumonia
- Streptococcus hemolyticus* Infections

Especially in meningococcal meningitis has penicillin been shown to cause a poorer and slower response than the sulfonamides. Most infections with actinomyces apparently respond well to sulfonamides; how many of them will respond to penicillin is at present questionable. Most infections caused by the *Streptococcus hemolyticus* respond promptly to the sulfonamides, but if they do not, penicillin can be used in addition.

In spite of the marked efficacy of penicillin in some infections, there are several important diseases in which it is not effective and the sulfonamides are effective. These are:

- Bacillary Dysentery
- Colon Bacillus Infections
- Friedlander Bacillus Infections
- Influenza Bacillus Infections

The group of diseases in which neither agent is effective is even larger. It includes:

- Botulism
- Brucellosis
- Lung Abscess
- Rheumatic Fever
- Rickettsial Diseases
- Salmonella Infections
- Tuberculosis
- Tularemia
- Typhoid Fever
- Virus Diseases in general.

With regard to the diseases which are primarily toxemic, such as diphtheria and tetanus, the main object of specific therapy is to neutralize the toxin. Neither penicillin nor sulfonamides will do this, but specific serum will.

The above lists serve to accentuate the fact that penicillin is a specific antibiotic agent, which while remarkably effective against some organisms, is totally ineffective in others. Any at-

tempt to use it when it is not indicated will not only cause needless expense and discomfort to the patient, but also may be the source of fatal delay in instituting the proper type of treatment. It is well to remember, therefore, that penicillin and the sulfonamides, like demolition and incendiary bombs, demand precision in their use.

H. F. D.

COMMUNITY BLOOD-PLASMA BANK

The Community Blood-Plasma Bank of Washington, D. C., Incorporated is a direct outgrowth of the plasma bank established under the Emergency Medical Service of the Office of Civilian Defense for the District of Columbia. Dr. John A. Reed, Chief Medical Officer of the Emergency Medical Service, initiated this project in 1942 for the protection of the citizens of Washington in the event of a war emergency from enemy action or sabotage. From the beginning Civilian Defense Plasma Bank was under the immediate direction of Dr. Roger M. Choisser, Assistant Chief Medical Officer in charge of the Civilian Defense Plasma Bank. Financial support was provided by the Washington Central Labor Union. Mr. Fred S. Walker, Treasurer of Civilian Defense Fund Committee, one of the officials of the Washington Central Labor Union, was instrumental in securing this support. The quota set for the Bank was 2,000 units. This was readily obtained and stored in ten Washington hospitals for distribution in case of military emergency.

The Civilian Defense Plasma Bank continued as a war emergency project under the District's Emergency Medical Service until the early part of 1944 when it was felt that a military emergency no longer existed. Dr. Reed then recommended to the District Commissioners that the plasma on hand be the nucleus of a community plasma bank. The Commissioners approved this recommendation and issued the following order C. O. 301,425/2 on May 10, 1944:

"That there is hereby established a civilian Governing Board to reorganize, operate, maintain and control a blood plasma bank for the District of Columbia and the metropolitan area, and the following-named individuals are hereby appointed to the Board: Dr. Charles Stanley White representing the surgeons, Dr. John A. Reed, the internists, Dr. John M. Orem, the Washington Association of Hospitals, Dr. Oscar B. Hunter, the Medical Society, Dr. Roger M. Choisser, the pathologists, and Fred S. Walker, the Washington Central Labor Union. Said Board is authorized to name its chairman.

"That the Governing Board is to have a free hand in the operation of the Plasma Bank, which shall be continued separate and distinct from the jurisdiction of the District of Columbia and the Office of Civilian Defense.

"That the Board shall be endowed with the authority to decide all matters pertaining to the operation of the Bank, employ personnel, order equipment, and formulate rules and regulations for the preparation and issue of plasma at a minimum cost to the general public.

"That the Board shall have authority to receive donations from civic fraternal and other organizations, funds from the sale of plasma and other sources, and make expenditures as it may be appropriate for the efficient operation of this project."

The Governing Board for the new organization, which was to collect and distribute blood as well as plasma, was immediately appointed. The Board was made up of the following: Drs. John A. Reed, Roger M. Choisser, Charles S. White, John M. Orem, Oscar B. Hunter, and Mr. Fred S. Walker.

The Board at its first meeting elected the following officers: Dr. Roger M. Choisser, President; Dr. John A. Reed, Vice President; and Fred

S. Walker, Secretary-Treasurer. On August 9, 1944 the Community Blood-Plasma Bank of Washington, D. C. was incorporated as a non-profit organization with the following purposes and objectives:

"To set up, maintain and operate a blood-plasma bank or banks for the collection, preparation, storage and issuance of blood and blood-plasma in the District of Columbia Metropolitan Area at a minimum cost to the general public on a non-profit basis, and in pursuance thereto, to lease, rent, buy, build, contract, own, mortgage, obtain, sell or otherwise dispose of, buildings or property needed in the conduct of said business or any part thereof; and to do and perform each and every lawful act and thing necessary, desirable and expedient to be done, in carrying on the purpose of the business and to accomplish the ends for which the body corporate is formed, and in general to do and perform every lawful act and thing necessary or expedient to be done or performed for the efficient conduct of said business as authorized by the laws of Congress, and to have and to exercise all of the powers conferred by the laws of the District of Columbia upon this corporation under said Chapter Six of the incorporation laws of the District of Columbia."

The Community Blood-Plasma Bank of Washington, D. C., Incorporated was officially opened October 1, 1944. The hospitals of Washington were asked if they desired to become participants in this project and recipients of its plasma and whole blood. Practically all of the hospitals in Washington except the governmental hospitals are now using the Bank. Plasma and whole blood from the Bank is available to all hospitals in the Washington area except government-controlled institutions, the latter having their own plasma and blood banks, and to the suburban hospitals in nearby Maryland and Virginia.

Plasma is stored in participating hospitals and accurate records are maintained by them. Whole blood is obtained when available only from the Bank headquarters at 1335 H Street, N.W., third floor annex. Affiliated hospitals are responsible for all plasma dispensed in their institutions or issued from their supply. For each 250 c.c. unit of plasma dispensed, a charge of \$15

is made and collected by the hospital. At this time a special card is given to the patient authorizing a donation of a pint of blood for each unit of plasma administered, such donation to be made by a member of the family or a friend.

The Blood Donor Center is located at the Police and Fire Clinic, 1018 Thirteenth Street, N.W., third floor. Full authorization has been granted by the Commissioners for the use of this clinic as a blood donor center. Donations may be made here every Tuesday, Wednesday and Thursday from 1:00 to 3:00 p.m. by appointment only. Appointments may be made by calling National 6000, branch 645 or 646. If a replacement is made by a blood donation, the card will be signed by the Director of the Donor Service. This should be returned to the hospital of issue for a credit of \$7.50. If no replacement is made within a period of 10 days, the full charge of \$15 will be made. Thus two methods of reimbursement are acceptable: (1) Full price of \$15 with no replacement, or (2) one-half price (\$7.50) with one replacement per transfusion. Each hospital forwards a Monthly Report by the 15th of each month to the Bank Headquarters. Those desiring to donate blood in advance of transfusions may do so by appointment and the blood or plasma will be held in reserve. A special card will be issued to such donors which, upon presentation to a hospital at time of transfusion, will be honored.

Thus, there is established in Washington a Community Blood-Plasma Bank furnishing plasma and whole blood to patients at a low cost. The Bank is, in the opinion of all who are familiar with its purpose and method of operation, one of the most progressive endeavors undertaken in the city of Washington and it is felt that it will afford an opportunity for thousands of citizens of our community to secure whole blood and plasma in unlimited quantities at a cost within their means. The support of the affiliated hospitals has been most heartening. As of the last of February 1945, 369 units of plasma have been dispensed.

OUR FIGHTERS COUNT ON US

A salute to Dr. W. Calhoun Stirling who again has been chosen by the District of Columbia War Finance Committee to be Chairman of the Medical Division for the Seventh War Loan! Dr. Stirling announces the following members of his Advisory Committee: Mrs. Edward E. Quayle, Mrs. Elizabeth Rogers, Miss Hattie Gibson, Miss Tommie Bolton, Deaconess Margaret Bechtol, and Drs. Francis J. Eisenman, John M. Orem, William J. Cusack, Leo B. Gaffney, Arch L. Riddick, Fred A. J. Geier, and Colonel N. L. McDiarmid.

This makes Dr. Stirling's fifth term as Chairman of the Medical Division, a distinction which reflects the capable job he and his associates have done in the past. His experience in war financing must be of incalculable help to the District War Finance Committee, but it would be folly to assume that Dr. Stirling and his Committee do not face a bigger, more important task than ever before. The Division's Seventh War Loan Quota has been fixed at \$1,250,000, which is considerably larger than any previous quota. However, war financing continues essential even as victories are gained.

The cost of the conquest of Iwo Jima was a

severe shock to any high hopes we may have had for a quick knockout blow against Japan, once Germany is overpowered. Twenty-one thousand Japs died on Iwo. The handful of prisoners taken were too shell-shocked to continue fighting. Every inch of the little island was won only at heavy cost to the Marines. Casualties were the heaviest in Marine history—almost 20,000, of whom more than 4,000 were killed.

Yet Iwo Jima is merely an outpost of Japan, some 750 miles from Tokyo. With what fanaticism the Jap will fight as we draw closer to his homeland, none can guess. But we may be sure that it will transcend anything we have yet faced in the reckless squandering of human life. The job ahead of our fighting forces in the Pacific is a sobering one. Our fighters will need every ounce of help we can give them. Halfway measures will no longer suffice. We are getting deeper and deeper into the relentless grip of war. And the deeper we get, the more we must sacrifice, if victory and a lasting peace are to be made secure.

It is a time for stark realism. It is a time for all of us to pitch in and give Dr. Stirling and his Committee our full measure of support. They have earned it. They will need it.

In and Out of Focus

BY THE OBSERVER

Our Medical Society Unique

The Medical Society of the District of Columbia is unique in many respects. Although its Active membership is limited to physicians maintaining their offices in the city of Washington, it is a state medical society. All other medical societies situated in large cities are county societies. Our Society is also distinctive because of the fact that it is located

in the Nation's Capital. This has had a decided effect upon its policies and activities.

All laws governing the District of Columbia are enacted by the Congress of the United States. As is well known, citizens of the Capital have no vote and therefore no elected representatives in the Congress. This places them in the unenviable position of having laws enacted by legislators who are not primarily interested in

their problems. Despite this handicap, citizens, civic groups and organizations of various sorts are not without influence. Their views do have a bearing on decisions of legislators.

Although most legislation relating to the District is of a strictly local nature, some of it has implications for the country generally. The perennial anti-vivisection bill is an example. The effect its enactment in the District would have on state legislative bodies is only too obvious.

Our Society naturally has a more intimate knowledge of national health legislation before the Congress than do other state medical organizations. Its representatives attend Congressional hearings and often talk with those directly responsible for the introduction of this legislation. Results of these contacts are reflected in the material which appears in the MEDICAL ANNALS and certainly in your Observer's column.

Most state medical journals devote their pages to matters which bear directly upon the practice of medicine in their respective states. The editors of the MEDICAL ANNALS, because of the Society's unique situation, have developed a deep interest not only in what is happening in Washington but throughout the Nation.

Your Observer has been engaged in medical organization work in the Capital for several years. This experience has given him a better understanding of the issues which confront physicians generally. It has also afforded him an opportunity of observing at first hand the strength and shortcomings of organized medicine on a national and state level.

So being situated in Washington has its advantages as well as its disadvantages. Your Observer is inclined to believe the former outweigh the latter.



*Honor Where
Honor Is Due* Few men are as beloved and highly respected by their intimates as Dr. Olin West, Secretary and General Manager of the American

Medical Association. Although he has a host of friends in the medical profession, the rank-and-file know little about him except that he is an official of the Association. The reason for this is that while he likes people, he dislikes publicity and would rather that others hold the spotlight.

Upon the shoulders of this tall, rugged, Tennessee physician has fallen the administration of the affairs of the American Medical Association during the most difficult years in its history. Only a man of great physical strength and indomitable will could have measured up to this task. Even those who differ with him on controversial medical issues admit that in his official capacity he has shown himself a man of extraordinary capabilities.

Medicine has never had a more devoted champion than Dr. West. He looks upon the practice of medicine as a sacred calling. The invasion of commercialism even to a minute degree troubles him deeply, for he is sensitive to criticism of the profession to which he is unswervingly loyal. Throughout the years he has labored tirelessly to maintain the highest standards of medical education and practice. No matter what else may happen to the medical profession, he insists that nothing must be allowed to impair the quality of medical service.

Perhaps the most admired characteristic of Dr. West is his trustworthiness and honesty. He expects others to be likewise. Unfortunately this has not always been so.

Lest the impression be gained that praise is being lavished on a man whose task is finished, your Observer hastens to disabuse the minds of his readers. These remarks have no other purpose than to bring into clearer focus a man who has and is continuing to serve the medical profession with honor and distinction.



*"... a
Stigmatizing
Name"* Differences of opinion as to the application of the term "psychoneurosis" have previously been reported in this column.

It will be recalled that Major General David N. W. Grant, the Air Surgeon, protested the indiscriminate use of the term, stating it was his opinion that combat personnel suffering "operational fatigue" were not necessarily psychoneurotic.

His position is supported by Lt. Colonel Jackson M. Thomas of the Army Medical Corps, Associate in Psychiatry at Harvard Medical School and Superintendent of Channing Sanitarium, Wellesley, Massachusetts (on leave of absence), whose article, "The Use of the Term 'Psychoneurosis,'" appears in the February 1, 1945 issue of *New England Journal of Medicine*. Colonel Jackson writes:

"If the manifold conditions under which this war is being waged are borne in mind, it seems reasonable to ask what the normal reactions under these ordeals might be. Alternating between battling a cunning and skilful enemy and contending with long periods of idleness, homesickness and boredom in the cold of the Arctic, in the heat and disease of the tropics and in the dust of the desert put every man's emotions under a strain. Add to these factors delays in the delivery of mail or still worse, the arrival of letters and hometown newspapers in which the soldier is told that the people back home are continuing to motor to Florida in the winter and to the Berkshires in the summer, and the soldier may be granted a variety of emotional reactions in his foxhole. Some of these will be psychoneurotic and others psychotic in nature, for experience has shown that in any large organization of men a certain percentage inevitably manifest mental disorder. Others, however, will be mere responses to the situation—unlinked to unconscious factors to which one is accustomed to attribute the symptoms of functional nervous disorder."

In the course of his article, Colonel Thomas offers case histories to prove his point that "A widespread misuse of the term 'psychoneurosis' in the present war has made the treatment and disposition of cases placed in this diagnostic classification more complex than that of the psychoses. Some of the difficulty is due to the fact that the psychiatrist is too often unfamiliar with the life of a soldier in the field." He then offers the following conclusions:

"...the frequency with which the diagnoses of a psychoneurosis is made raises a suspicion that psychiatrists have encouraged a shrouding of factors influencing emotion in an ill use of terminology. In doing so they have thrown the problem of psychoneurosis out of focus with what seems to be the facts. The prompt recovery of many patients when they are removed from a difficult situation adds weight to this assumption.

"I saw patients in England, members of the Air Force, who were in combat over the Continent and others who had not been in combat, and considered them unsuitable for further duty. They were returned to the United States with a diagnosis of psychoneurosis. Before they arrived, I was ordered to report for duty at the same hospital to which they were later admitted. Reëxamination of some of these patients disclosed that a remarkable improvement had taken place in them, especially in those who had not been in combat. This observation opened my eyes wider to the haste that I had been guilty of in the use of the term 'psychoneurosis.' In some cases I had mistaken boredom, homesickness and what the British call 'morale lesions' for symptoms of a nervous disorder.

"Recent use of the word 'anxiety' illustrates further how muddled is the present knowledge of the psychoneuroses. There are psychiatrists who regard the familiar fear of a soldier in a dangerous situation as a measure of the emotion of an anxiety neurosis. This is tantamount to calling all frightened and bewildered soldiers psychoneurotic. There was a time when 'anxiety' was considered an appropriate word for the emotion present in clinical states characterized by palpitation, dyspnea, sweating, anxiousness and apprehension. Of late, however, this word has been used so loosely that it has almost acquired buoyant and ethereal qualities. This careless use of the term does injustice to the Army, the soldier and the taxpayer. So does the term 'depression' when it is applied to simple nostalgias. These latter conditions were often seen in World War I. When the cause, which was absence from home or some factor related to it, was removed, the patient promptly recovered. Salmon cited cases who recovered on the voyage home, some doing this so rapidly that a suspicion of malingering arose. Similar recoveries are being seen in the present war. They should allay the fears entertained with regard to some of the erroneously classified psychoneuroses.

"It may be argued that a disappearance of anxiety and insomnia under the conditions cited does not constitute a cure, and that the unconscious must be exposed to remove the real trouble. This point of view may be correct for some true psychoneuroses. The tension and anxiety of the cases discussed here, however, seem to have

arisen from obviously trying situations rather than from hidden conflicts.

"If the reactions under discussion are to be excluded from the psychoneurotic group, it is in order to ask what name is to be given them. The idea that an emotionally upset soldier is not a particular example of a recognized disorder is disturbing to some psychiatrists. Nor does modern warfare permit the outlet that Joshua seems to have had before the siege of Jericho, when it was directed that 'the fearful and faint-hearted return unto his home lest his brethren's heart faint as well as his heart.'

"No one who is familiar with the fleeting fashions in psychiatric nomenclature wants to be caught adding another term to the confusion. Moreover, it is obvious from what has been said that I believe that some of these cases present problems in morale, discipline and stamina. If this is so, it follows that any term connoting a mental disorder will cloud the issue. The answer to the question seems to rest in the prophylactic orientation program now under way—the prevention of states that require a stigmatizing name.

"For the patients who reach a hospital, regulations permit the use of the terms 'observation—no disease found' and 'simple adult maladjustment.' The latter term does not always fit the picture, but for the patient returning to duty it is less of a handicap when he reaches his unit or a replacement pool than the term 'psychoneurosis.'"

These conclusions confirm your Observer's belief that another term might well be substituted for the offending one. It may be true that the people should be enlightened as to the true meaning of the neurosis but that will require a long and intensive educational effort. The uneasy feeling about persons suffering from emotional disturbances is deeply ingrained in the lay mind. In view of this situation, our mild psychiatric casualties should not have an additional handicap placed upon them.

Your Observer recalls an incident related recently by an American Red Cross worker. A young veteran, who had been returned home with a diagnosis "psychoneurosis," was invited, with several of his comrades, to a party. He resolved to experiment by telling the truth to those inquiring about his disability. He was promptly shunned by those present. Later he had occasion to go to another social affair and there he reported his disability as "battle fatigue,"

whereupon he was accorded all the honors of a hero.

Of far more importance is Colonel Jackson's point that mistakes have been made in diagnosis. This should make psychiatrists all the more wary of using a "label" which, in addition to being a handicap, may be incorrect.



***"I Have
Never Favored
Socialized
Medicine"
—Pepper***

Times change, as do individuals, and it seems that Senator Claude Pepper of Florida is no exception. Once severely critical of the medical profession, he now views organized medicine's efforts to cope with knotty medical problems much more sympathetically. Recently, in addressing the Atlanta Conference of the Council on Medical Service and Public Relations, he promptly disposed of the impression that he is antagonistic toward physicians.

"When I started into this subject, some thought it was an effort on the part of Pepper of Florida to inflict socialized medicine on the country. I reiterate that I have never favored socialized medicine. I live in the field of politics and am not angry with any of my doctor friends who misinterpreted my views. I have no desire to impair the integrity of the profession or the right of the patient to make a free choice of doctor, dentist or nurse or anything else we think of as Americanism."

As the following statement reveals, the Senator believes that the medical needs of the country can be met on a voluntary basis. In view of the exhaustive investigation of medical care made by the Senate Subcommittee on Wartime Health and Education, of which he is the Chairman, this is significant.

"We have the Wagner-Murray-Dingell bill, and that bill contemplates compulsory insurance. It would undoubtedly cover many people and bring them into an insurance scheme and provide vast quantities of funds not now available for these facilities. That is compulsory in character. I am not quarreling with the profession that seems to be against the bill. They feel that the ill of it will exceed the good and we want a directive from this point. Only a few claim that the present sys-

tem is adequate for every one. My problem is to find the answer between the present systems. There is the feeling that we are to bring conflicting opinions together.

"I started off with the idea that first I want to preserve the system of voluntary membership and payment. If you are going to make the program voluntary in character and if it is going to be available to a great amount of persons, payment must be low. Twenty-one per cent of all the American people, of families in the United States, have an annual income of less than \$1,000 per family. Twenty-nine per cent of all the families in 1942 had an annual income between one and two thousand dollars. Twenty per cent of all our families had an income between two and three thousand dollars, 20 per cent between three and five thousand dollars, 10 per cent in excess of five thousand dollars. Only 10 per cent have incomes in excess of five thousand dollars. Every one here has more than ten thousand dollars. We all realize how hard it is to get along with our incomes and live according to a decent way of living. You are practicing medicine for a livelihood. I don't think it is put on the doctor to give away his services. I think that if there is going to be a donation, groceries and legal aid should be given too. If you do anything other than that you are bound to charge some one else more or lose out.

"I have been thinking in terms of building the hospitals through a plan sponsored by the hospital associations and councils. When we get enough hospitals and doctors I think it should be a plan of insurance to which membership is open on a voluntary basis, each member paying either a fixed amount or a graduated amount according to income. It might be determined by income taxes paid, in order to have some standard. We might have everybody pay a certain amount of money to justify having the same system for the rich and poor alike. The difference between the total receipts of the plan and the total cost of operating the plan would be made up by federal and state subsidies. The disparity in the long run would not be as great as the first way. It is more consistent with our idea that there should be equality between what a man pays and what he can pay. A man paying an income tax on less than \$500 would pay say 50 cents a month for each member of his family and himself. A man paying taxes on an annual income as much as one thousand dollars would pay a dollar a month. Next scale on up. We might get on up to where a well-to-do man would perhaps pay ten dollars a month per person. He might prefer to do it that way rather than go to his own doctor or private hospital. It still preserves the patient's choice of hospital, doctor, nurse to a considerable degree by giving a rich man the right to go to his own doctor and let that doctor turn in his bill to the associa-

tion. If the association and doctor want to work out a reasonable plan he might charge a little less than he would ordinarily charge. I don't know. I am just thinking out loud. I am thinking of a statewide association operated under the supervision of a statewide council created by a state legislature and appointed by the governor properly constituted. I had in mind the statewide plan, because if you set up a little association down here in the county, sparsely populated, the doctors won't go there and practice. It would be a losing organization. My concept is to make the state the basis. I would like an effective state council with a federal council aiding to work out the necessary arrangements.

"What we contemplate is coöperation between state councils and federal councils by which the states are constantly experimenting in this field, working out new technics and always having a certain amount of latitude, maybe constantly recommending to the federal council plans and programs to be worked out and getting federal aid. If you had the state as a basis in setting up insurance schemes, deficiencies between income and disbursement (provision of physical facilities) not part of outlet but just operation costs would be made up by subsidies. You can't do it all at one time. You can't start any of the construction before the end of the war. I don't know what the amount should be. I don't know how it should be graduated. I don't know how to integrate the plan to include Blue Cross schemes and private insurance schemes which insure their workers. I do know that a plan that includes only the worker and not his family is not a good plan."



Lay Executives in Medicine

Although a comparatively new figure in the medical field, the lay executive in medicine seems to have established himself firmly. Among the positions he has filled are those of hospital administrator, business manager of clinics, of medical service and hospitalization plans, and executive officer of medical organizations. It is the latter with which your Observer is concerned here for it is with this field of endeavor that he is most familiar.

The lay executive secretary of a medical society made his first appearance about the time of World War I. So it is about a quarter of a century since he made his bow in medicine. The record shows that by and large he has given a good account of himself.

In the beginning there was considerable skepticism on the part of many physicians as to the value of a layman to a medical organization. After all, what did he know about medicine? Only a physician could deal intelligently with medical matters. When the layman proved himself competent for his task, skepticism gave way to approval.

Your Observer believes it is fair to state that the societies who employ lay executives are more efficiently administered than those who do not. There are exceptions, of course, but this opinion has been corroborated by physicians familiar with the conduct of medical organizations.

Lay executives of medical organizations are fully cognizant of their limitations, some of them so much so they suffer from an inferiority complex. They have advantages, however, over a physician in a similar position. For example, their status in a medical organization is a neutral one. They are not in competition with other physicians so they can deal more objectively with matters which come before them. If competent, they can represent an organization more effectively in the civic life of the community. This is in part due to their training and the time which they can devote to such matters.

Of course, lay executives are not uniformly successful. Some are better adapted to this type of work than others. There are mediocrities who do not do the job as well as they should, who lack initiative, drive and imagination. Capable or not, they have been intensely loyal to the organizations employing them. For the most part, they compare favorably with executives in other lines of work.

In the opinion of your Observer, the qualities which make a good lay executive of a medical organization are these: integrity, a sincere interest in people and an ability to get along with them, organizational ability, a broad cultural background, imagination, efficiency, and some talent for writing and speaking. It is his

belief that there are a number in this country today who meet these qualifications.

Eight state medical societies now employ lay executive secretaries. The exact number of county societies employing lay executives is not known but thirty-five is a close estimate. Reports indicate that their number is growing. So the lay executive in medicine is undoubtedly here to stay.



*Quality of
Medical Care
Variable*

It is often true that those with whom we disagree stimulate our thinking. On the other hand, we weary of those who never stray from familiar paths even though we may be in general agreement with their views.

Your Observer was privileged to attend sessions of the Second National Conference on Social Security sponsored by the Chamber of Commerce of the United States held in Washington early in January. The program offered was highly interesting, all shades of opinion being represented as the following roster of speakers indicates: Marion B. Folsom, Treasurer, Eastman Kodak Company; Edwin E. Witte, Professor of Economics, University of Wisconsin; R. L. Sensenich, M.D., Trustee of the American Medical Association; Basil C. MacLean, M.D., Director of Strong Memorial Hospital, Rochester, N. Y.; E. A. Van Steenwyk, Executive Director, The Associated Hospital Service of Philadelphia; W. A. Milliman, Associate Actuary, Equitable Life Assurance Society; Nathan Sinai, Dr. P.H., Professor of Public Health, University of Michigan; Mortimer W. Newton, Chairman, Rhode Island Unemployment Compensation Board; Henry S. Beers, Vice President, Aetna Life Insurance Company; William G. Sutcliffe, Dean, Boston University College of Business Administration.

Dr. MacLean attacked his subject, "Medical Care Problems," vigorously and without gloves. Of particular interest were his views on the quality of medical care which he said was variable.

"In buying most things," Dr. MacLean stated, "the individual's experience and common sense usually enable him to judge the quality of the product but witness the number of people who patronize chiropractors, naturopaths and all the other types of charlatans and witch doctors. Among licensed physicians it is difficult for the public to tell who is competent and who is not. Medical licensure is no guarantee of professional skill for it is based only on a prescribed course of study and examination. Once licensed, a doctor is always licensed unless convicted of some extremely antisocial act.

"The medical profession has assumed the responsibility of policing its own members. Now medical societies are a power for good professional conduct, but it is extremely difficult to judge the extent of their influence. In this country the penalties for misconduct are light. When they are imposed, which is seldom, it is as often as not for conduct deemed bad for the medical society as an organization, as for conduct prejudicial to the interests of the patient. Further, a substantial number of physicians, possibly those most in need of regulation, do not belong to medical societies and are thus beyond their jurisdiction. Membership in a medical society, like licensure, therefore, is no guarantee of competence. The state and the medical society assume that the physician is as competent 35 or 40 years later as he was at the time he was licensed. In New York State, for example, the recognition of specialists is in a state of confusion. Where the expenditure of public funds is concerned, a physician may, as in Workmen's Compensation, be considered competent in a special field if so judged by a committee of his county medical society. To render special service for another governmental agency, he may be required to be approved by a national, non-official board of physicians. Or the governmental administrator may have the power to accept a physician as a specialist on rather elastic grounds, depending upon general reputation and local circumstances as guides. Where public funds are not involved, the patient as a rule must rely upon the judgment of the physician who refers him to another physician for specialized treatment.

"Affiliation with a recognized hospital is perhaps the best assurance to the patient that the care he received will be of good quality. Unfortunately, not all physicians, only 4,500 out of 18,000 in New York City for example, have connections with recognized hospitals but it is certainly not implied that all the others are incompetent. Service on the staff of a good hospital,

however, offers the physician opportunity to study and use modern diagnostic and curative facilities, provides stimulating contacts with physicians in the same or other fields, permits joint discussion and study of current developments in medicine and, through clinical and pathological conferences, enables evaluation of the methods employed. In other words, the voluntary hospital system provides continuous postgraduate education for staff physicians. Attempts to furnish the equivalent for non-staff members have for the most part consisted of articles in medical journals and lectures and addresses at medical society meetings and special institutes under the sponsorship of the medical societies, sometimes with aid from state health departments. The results are often disappointing because physicians most in need of instruction frequently fail to attend. One method proposed to insure continued professional competence is to require physicians to take examinations at intervals of, say, five years. Failure would necessitate further study before the physician could be licensed for an additional period. This proposal seems rather extreme and it is doubtful if it would ever be adopted. Another proposal is to provide and require periodical resident postgraduate education at public expense, as obtains in some educational systems.

"A system of regionalization of hospitals offers perhaps the best hope for improvement of quality. The gearing together of the facilities for diagnosis and treatment of the large medical centers or teaching hospitals and the smaller institutions is recommended by many. Further out on the periphery of such a plan, but equally important, is the provision of diagnostic aid to doctors in areas where there is no hospital at all. Such plans promise better care for the patient and continuous education for the practitioner."

No physician will deny the fact that the quality of medical service can be improved. In fact there will always be room for improvement. Undoubtedly the proposals made by Dr. MacLean have merit but we wish to remind him that conditions vary in different parts of the country and it is not always true that the penalties imposed upon members of the medical societies for misconduct are "as often as not for conduct deemed bad for the medical society as an organization." That certainly is not the state of affairs in Washington which, like many other medical societies, has established a grievance committee to which complaints can be submitted with the assurance that they will

be fairly and objectively dealt with. It also happens that only a small percentage of practicing physicians in the Nation's Capital are not members of medical societies. It is also a fact that the majority of physicians have some connection with a recognized hospital.

Again, it is clear that there is room for improvement. But we have come a long way since the turn of the century. The quality of medical service in the United States today is superior to that of any other country and we are continuously seeking to improve it. No one needs to doubt that our efforts in this direction will continue.



Records of Deceased Physicians

The alert *Ohio State Medical Journal* usually contains information of practical value to physicians. With the aid of Mr. J. W. Holloway, Director of the Bureau of Legal Medicine of the American Medical Association, the *Journal* in its February number offers advice regarding the disposition of records of deceased physicians.

"There are three ways in which a physician's medical records may be disposed of after his death," the *Journal* states, "They may be destroyed. They may be transferred to another physician. They may be given to former patients.

"In the absence of specific law requiring that records be kept for a definite time, there is no legal reason against the destruction of records by the physician's estate. However, such destruction might work to the detriment of some patients whose records would conceivably be of value if placed into the hands of a succeeding attending physician.

"Also, such action might destroy records which would be necessary to rebut claims based on alleged malpractice, filed within the statutory period. How long records should be kept for this reason is a question which the legal advisors of the estate must decide. Obviously, records that may be of value in the collection of unpaid accounts should be kept until such bills are paid or otherwise disposed of.

"An estate may transfer medical records to another physician. If this is done without the consent of the patients involved, the transfer can be of little value to such patients unless they are notified by either the estate or the physician receiving the records. They would seem

to raise ethical implications as it could easily result in solicitation of patients, directly or indirectly.

"There is no legal obstacle to the transfer of records to the patients themselves. However, such procedure raises professional questions as it is not advisable in many instances for patients to have access to a physician's records because of the danger of misunderstanding, misinterpretation or hysteria.

"Therefore, it would seem wise for estates to pursue the following procedure in disposing of a physician's records:

"Destroy the records of deceased patients after they have been retained possibly until the time has elapsed within which suit for malpractice may be instituted or until their value in connection with unpaid bills has ceased to exist.

"With respect to records of patients still alive, send a brief notice to such patients, or their parents or guardians, advising of the physician's death and stating that the records of the deceased physician will be destroyed after a stated period unless a request is received asking that they be transferred to another attending physician.

"Physicians might consider leaving instructions along these lines in their files. In doing so they would be performing a valuable, final service to their patients."



Issuing of Borderline Certificates Continued

The controversy between the Commission on Licensure of the District of Columbia and the Maryland State Board of Medical Examiners came to a climax

at a meeting of the Montgomery County Delegation of the Maryland House of Delegates at Annapolis in February. In attendance at the hearing were Dr. George C. Ruhland, Secretary of the Commission, and Theodore Wiprud, Secretary of the Medical Society of the District of Columbia. Representing the Maryland Board were Dr. Erasmus H. Kloman and Dr. John T. O'Mara, Secretary of the Board.

The Delegation was favorable to the position taken by the Commission and the District Society. Upon its insistence, the Maryland Board rescinded its action and voted to continue issuing borderline certificates for the duration of the war.

It was revealed at the hearing that there was a law on the statute books of Maryland reading:

"Any physician who may change his residence from the District of Columbia to the State of Maryland, or who while living in the District of Columbia shall desire to practice medicine or surgery in the State of Maryland shall, upon application to the examining board of the State of Maryland, be entitled to a license without fee and without examination; provided, that the application be properly endorsed at the time it is presented by the examining board of the District of Columbia, certifying to the proficiency and professional standing of the applicant; and provided further, that the examining board of the District of Columbia shall, under the laws thereof, grant like and equal privileges to licensed physicians of this State who may remove to said District of Columbia, or while continuing to reside in this State may desire also to practice in said district."

This law apparently had been overlooked by those involved in the controversy. Since the Maryland Board rescinded its action a bill has been introduced in the Maryland House of Delegates reënacting this law with amendments. The amendments read:

"Any physician who is licensed to practice medicine or surgery in the District of Columbia, whether by reciprocity or by original examination, shall upon application to the examining board of the State of Maryland, be entitled to a special license without fee and without examination to practice within that portion of the Maryland-Washington Metropolitan District lying within the Montgomery County, as said area is defined in Section 953 of the Code of Public Laws of Prince George's County (1943 Edition) and Section 1 of Ch. 1008 of Acts of 1943."

This bill was received favorably by the Judiciary Committee and will soon be voted upon by the House.

Physicians desiring a borderline certificate should communicate with Dr. John T. O'Mara, Secretary, Maryland State Board of Medical Examiners, 1215 Cathedral Street, Baltimore 1, Maryland.

The Society has taken the position that the arrangement under which borderline certificates are issued to physicians in the District and sections of Maryland, within the Metropolitan Area, be permanent. Whether it will be necessary for the Society to pursue this matter further depends upon the action taken on the bill which

has been introduced in the Maryland legislature and the subsequent position of the Commission on Licensure of the District of Columbia.

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Having read a news report *A Telephone at Your Side* that the "walkie-talkie" would be placed at the public's disposal following the war, your Observer decided to call upon an official of the Federal Communications Commission for details. It had been announced that the "walkie-talkie" could be used, for example, to establish a physician's calling service. Immediately its adoption by MEDICAL BUREAU came to mind.

The official pointed out that no details could be given until after the cessation of hostilities. He doubted whether the "walkie-talkie" would be suitable for all the purposes reported in the press. But he had some things to say about mobile radio service which your Observer believes will be of interest to readers of this column.

He said that radio-telephone equipment would undoubtedly be installed in taxis, buses, doctors' cars and ambulances. He pictured the physician in the postwar period having a radio-telephone receiver and transmitter on his automobile panel. With this equipment he could keep in touch with hospitals and other institutions similarly equipped, no matter where he happened to be. For example, if he failed to give orders for the care of his patient, he would park for a moment, pick up his receiver-transmitter gadget and call the hospital. Then he might inform MEDICAL BUREAU of his whereabouts.

Your Observer overlooked asking how calls would be transmitted to the doctors while en route from office to home or when out on calls. Subsequently he was informed that physicians would perhaps be allocated special frequencies. Each physician would have a code number to which he would respond.

Well, one could let his imagination run riot as to what the world will be like tomorrow. It is apparent that the telephone will haunt the doctor more than it does today. He will have to walk

if he is to get away from it. And that may not be a bad idea either, because more often than not the exercise would be good for him.



*Postgraduate
Course in
Physical
Medicine*

Despite the war and the handicaps under which committees of the Society undertaking to further medical knowledge labor, postgraduate education goes on. Each year since Pearl Harbor succeeding Committees on Postgraduate Education have offered courses of a timely nature. During the month of April the Committee will sponsor a Postgraduate Course in Physical Medicine. Considering the progress which has been made in physical medicine and the utilitarian value of the Course, a large enrollment is expected.

Lectures scheduled in this Course are:

April 9, 1945—"The Physical Basis of Physical Medicine," FRANCIS O. SCHMITT, PH.D., Head of the Department of Biologic Engineering of the Massachusetts Institute of Technology

April 16, 1945—"The Future of Physical Medicine," FRANK HAMMOND KRUSEN, M.D., Head of the Section on Physical Medicine, Mayo Clinic

April 23, 1945—"Clinical Aspects of Physical Medicine," GEORGE MORRIS PIERSOL, M.D., Director, Division of Physical Medicine, and Professor of Medicine, Graduate School of Medicine, University of Pennsylvania

No comment is necessary on the choice of lecturers for they are eminent in their field and known to the medical profession here and elsewhere. The Committee deserves the highest commendation for its selection of both speakers and subject matter.

Invitations to participate in the course have been extended to members of the Society and nearby county medical societies, medical officers stationed in or near Washington, nurses and physical therapists.

*Society Co-
operates with
Philippine
Government*

Our citizens deeply sympathize with the gallant people of the Philippine Islands. Their suffering has touched the hearts of all Americans. The ruthless invader has devastated their cities, perpetrated unbelievable cruelties and deprived them of food and other necessities of life. The result has been tragic beyond description. Only prompt and generous assistance will restore decent living conditions within a reasonable time.

The Executive Board of the Medical Society recently received a letter from Jaime Hernandez, Secretary of Finance of the Commonwealth of the Philippines, calling attention to the shortage of medical supplies in his country. Mr. Hernandez had discussed the situation with Dr. John H. Trinder, a member of the Society, the latter suggesting that a considerable quantity of drugs might be obtained from physicians. He asked the Medical Society's help in collecting samples of medicines which members might be willing to contribute for shipment to the Philippines. Mr. Hernandez wrote, "The need of medicines is very urgent and I am confident your Society will extend its valuable coöperation to this laudable project."

The Board instructed the Secretary to inform Mr. Hernandez that the Society would coöperate. It appointed Dr. Trinder to represent the Society in the undertaking. Dr. Trinder, with the assistance of Filipino physicians residing in the city, is now endeavoring to obtain from physicians' offices all the sample medicines available.

Your Observer feels certain that this project will receive the wholehearted support of the Society membership.



*The
Secret
Document*

Another of the Medical Society's committees concerned with the war was in session. Although the hour was late, there was no letup in

(Continued on page 192)

REPORT OF THE EXECUTIVE BOARD*

This is the second report by the Executive Board to appear in the *MEDICAL ANNALS* during the current organization year. Due to limitations of space the report is not published in its entirety. Where deletions of importance have been made they have been noted.

Few of our members have familiarized themselves with the Society's Constitution and By-laws. This is, perhaps, natural though it would be desirable if more would do so. For example, every member should acquaint himself with the purposes of the Society. They are set forth in Chapter I, Article II of the Constitution and By-laws which reads as follows: "*The object of this Society shall be the promotion of the science and art of medicine and sanitation and the common interests of its members and the public.*" This provision, especially that portion in italics, makes it clear that while we are primarily concerned with the science of medicine we have many other interests.

In this connection, if all of the multifarious activities of the Society, outside the scientific, were embodied in the Board's periodic report to you, it would be a voluminous document indeed—one which would be informative but which would try your patience beyond endurance. So your Board, in giving an account of its stewardship, is limiting itself to matters of policy and activities it considers of greatest importance.

Amendments VII and VIII to Constitution and By-laws (to be voted on) and Amendments IX and X (for action in May): Amendments VII and VIII were presented at the last regular meeting of the Society and will be voted on this evening.

As you were informed in the November report, the Board appointed a subcommittee to study proposed changes in the Constitution and By-laws. Amendments submitted here for action are those which were prepared by this subcommittee with the aid of the Society's legal counsel and subsequently approved by the Board.

The first amendment offered for consideration reads as follows:

AMENDMENT VII

Section 1. Section 3 of Amendment II to the Constitution and By-laws is hereby repealed.

Section 2. A business meeting shall be held on the first Wednesday in May. Other business meetings shall be held when ordered by the Society or the Executive Board, or upon the written request of any thirty-five members. All other meetings shall be scientific meetings. Pending matters usually considered at business meetings, including the election of members, may be taken up at the next subsequent scientific meeting as emergency business.

* Adopted at the second Business Meeting of the Society, March 7, 1945.

This amendment would repeal that portion of Amendment II, Section 3, which provides that business meetings shall be held on the first Wednesdays of March, May and November and substitute therefor the sentence (see Amendment VII, Section 2, above) reading, "A business meeting shall be held on the first Wednesday in May." The remainder of Amendment VII, Section 2, reads the same as Amendment II, Section 3.

Attention might be called to the fact that Article I, Section 2, Chapter III provides that the first meeting in May of each year shall be the Annual Business Meeting of the Society and shall be devoted to the reception of annual reports and other annual business, including the election of officers, and that Article II, Chapter VI, specifies that nominations for office shall be made orally at the first meeting in March. Neither of these provisions is affected by Amendment VII.

The second amendment, Amendment VIII, which the subcommittee submitted to the Board, and which it also approves, is the following:

AMENDMENT VIII

Section 1. Sections 4, 5 and 6 of Article I of Chapter X of the Constitution and By-laws are hereby repealed.

The Sections repealed by Amendment VIII deal with controversial matters more or less related to the recent trial. In view of the fact that the Department of Justice has held these Sections of our Constitution and By-laws to be illegal, your Board is of the opinion that Amendment VIII should be adopted.

The following amendments are presented at this meeting and will be voted on in May:

AMENDMENT IX

Section 1. Section 2 of Amendment V of the Constitution and By-laws is hereby amended by adding thereto the following proviso: Provided also that doctors of medicine residing in or having offices in the District of Columbia, representing the American Medical Association and the American Red Cross, may be elected to active membership by the Society.

AMENDMENT X

Section 1. Article III of Chapter IV of the Constitution and By-laws is repealed as of December 31, 1945.

Section 2. Associate members, commencing January 1, 1946, shall pay ten dollars.

In regard to the above amendments, your Board will not go into the reasons for their proposal at this time.

It will enlarge upon its position in regard to them at the May meeting.

Change in Name of Committee on Rehabilitation of Service Physicians: It has occurred to your Board that the choice of the name of the committee to aid returning service physicians was not a particularly happy one. Our returning physicians do not wish to be looked upon as in need of rehabilitation but as entitled to any assistance that we can give them. For this reason it is recommended that the name of this committee be changed to the Committee on Service Physicians.

More about Remodeling the Society's Building at 1710 M Street, N.W.: Those of you who attended the November business meeting will recall that the Board submitted its proposals for remodeling the Society's building at 1710 M Street, N.W. It went into detail as to the original cost of the building and the investment necessary if it was to be restored satisfactorily. As the building is in bad condition it was the opinion of the House Committee, concurred in by your Board, that halfway measures were not warranted. Complete restoration, in their opinion, was necessary and should not be postponed until after the war.

Except for the apartment on the first floor front housing MEDICAL BUREAU, the building is now used as a rooming house. It will be recalled that after remodeling it was proposed that the first floor be made available to the American Medical Association for offices of its Council on Medical Service and Public Relations. The BUREAU, it was suggested, should be moved to the second floor. The remainder of the building, it was proposed, should be converted into offices.

Your Board was largely influenced in its decision to recommend authorization to proceed with complete remodeling because the American Medical Association had indicated its desire to have its Washington office in the Society's building. The Society saw fit to give its approval with the understanding that the cost would be \$15,000 to \$20,000, these funds to be raised by refinancing the loan on the property and, if additional money was needed, by drawing on the Society's funds.

Since that time there have been a number of developments. The following Special Building Committee was appointed by the Board: Dr. W. Raymond Thomas, Chairman; Drs. Henry R. Schreiber, J. Chester Brady, George R. Huffman and Henry L. Darner. Drs. Thomas and Brady are also members of the House Committee. This committee employed an architect to make preliminary sketches. Discussions were held with Dr. Joseph Lawrence, Executive Director of the A. M. A.'s Council on Medical Service and Public Relations. He agreed with the Committee that the Society itself should use the first floor for MEDICAL BUREAU and additional

office space. At least a half of the second floor, it was proposed, should be made an annex to the library in this building to care for overflow crowds. The use of the remainder of the second floor had not been determined. The third floor was to be occupied by the A. M. A.'s Council.

The Committee recommended to the Board that it be authorized to proceed with its plans and if possible obtain priorities from the War Production Board. Within the past week, however, these plans have had to be abandoned. Dr. Lawrence has notified the Society that, although his Council was in favor of quarters in the Society's building, the Executive Committee of the Board of Trustees of the Association was not. Plans for remodeling the building will therefore have to be reconsidered in the light of this development. The Society has been approached by two other organizations in allied health fields who would like to rent space in the building. It seems advisable now to make a new survey of the whole situation and report further to you in regard to this matter at the May meeting.

Representatives Appointed to Federation of Citizens' Associations of the District of Columbia: At the regular meeting of the Board held in November, the late Charles B. Campbell personally submitted his resignation as a representative of the Society to the Federation of Citizens' Associations. He had served as the Society's representative faithfully and well for sixteen years but felt that his retirement was imperative because of the state of his health. Before relinquishing his duties he submitted a report of his accomplishments over the years, a record of which he had every reason to be proud. The Board accepted Dr. Campbell's resignation with regret and voted to recommend to the Society that he be cited for meritorious service. In view of his death, plans which the Board had in mind cannot be carried out, but the Board wishes to take the opportunity of stating that few members have served the Society as loyally as Dr. Campbell.

The Board has appointed Drs. Richard T. Sullivan and J. Ross Veal as the Society's representatives to the Federation for the ensuing year.

Society's History: It is no exaggeration to say that only a member who looks upon his task as a labor of love would devote the time necessary to writing a history of the Medical Society. The first history of the Society, completed by the late Dr. D. S. Lamb and his co-workers, covered the period 1817 to 1909. A second volume covering other phases of the Society's long history and bringing it up-to-date has just been finished.

The Chairman of the current Committee on History is Dr. John B. Nichols. Serving with him have been Drs. William J. Mallory and Joseph S. Wall. The

burden of research and writing has fallen to the lot of the Chairman. Members of the Committee reviewed the work when it was completed and pronounced it excellent. Dr. Nichols has turned the manuscript over to the Society and it is now in the process of preparation for publication.

The Society is deeply indebted to Dr. Nichols for a splendid historical document. Your Board is certain that the history will be widely read for the new light it throws on the period 1817 to 1909 and the interesting material which has been gathered on the years 1909 to 1945, perhaps the most stirring and significant in the Society's existence.

Gifts Received and Donated by the Society: Mention should be made of the gift received from the Columbia Historical Society, a framed portrait of Dr. Joseph M. Toner, the first President of that Society and one of the most important figures in Washington medical circles in the 1870's and 1880's. Dr. Toner was, by any yardstick, one of the National Capital's great figures. As President of the American Medical Association and President of the American Public Health Association, he was a national figure. He was also a scholar well known for his writings. The Board expressed the Medical Society's appreciation to the Columbia Historical Society.

A year or two ago a painting was found among some articles in the Society's possession. It was in very bad shape and its restoration was doubtful. It proved to be a painting of Robert Morris, one of the signers of the Declaration of Independence, so it was taken to the Smithsonian Institution which accepted it conditionally. Following many months of work, it has been restored. The Board presented it to the Division of History of the United States National Museum as a gift from the Society. The Board is sure the Society will be pleased that such an excellent repository has been found for this painting.

Annual Financial Report and Budget for 1945: [Space limitations will not permit the publication of the Report and the Budget. Members who are interested and could not attend the Business Meeting at which they were presented can obtain copies by calling the Society's office.]

Borderline Certificate Dispute: Your Board does not want to go into too much detail about the controversy between the Maryland State Board of Medical Examiners and the Commission on Licensure for the District of Columbia regarding the so-called borderline certificates. If members will refer to the Board's report presented at the November meeting, later published in condensed form in the MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA for December, 1944, they will find that this subject has been covered rather fully. Since then

there have been further developments, one of them being that the Maryland Board ceased issuing borderline certificates on November 1, 1944. The Commission on Licensure of the District retaliated immediately. At this turn of events, the Secretary of the Society directed a letter to both the Commission and the Maryland Board urging that the actions taken in regard to certificates be reconsidered. Quoting from the letter: "It [the Society's Executive Board] believes that steps should be taken immediately to arrive at an agreement whereby physicians within the Metropolitan Area be granted privileges to practice either in the District of Columbia or Maryland providing they hold regular licenses in the jurisdictions in which they have their offices. In other words, that within the borders of the Washington Metropolitan Area, perhaps as defined by military authorities, physicians be granted borderline certificates as in the past."

Your Board does not want to go into all the arguments advanced for taking this step. It does want to mention the fact that the Secretary of the Society appeared before a legislative committee of the House of Delegates at Annapolis at which time the position of the Board was affirmed. The committee was favorably impressed by the position of the Commission and the Medical Society. On Monday of this week the Commission on Licensure for the District was informed that the Maryland Board had voted to rescind its previous action and will issue borderline certificates for the duration of the war. Similar action will undoubtedly be taken by the Commission in the very near future.

Summary Report of Membership for 1944: A summary report of the membership discloses that on January 1, 1944, the Society's membership, including all classifications, was 1,167. At the year's end it was 1,198. However, 270 members had entered the armed services prior to December 31, 1944. Of those now in service, 206 Active and 41 Associate are still members of the Society and, of course, do not pay dues.

Your Board is very much pleased with this report and believes it shows satisfactory growth.

Nomination for Vice President of Washington Academy of Sciences: Under date of December 7, 1944, the Washington Academy of Sciences addressed a letter to the Medical Society of the District of Columbia advising that an election would be held on January 18, 1945, at which time officers would be chosen. The Society was requested to submit the name of its nominee for Vice President so that it could be presented at the above meeting.

The Board nominated Dr. Fred O. Coe to succeed himself as Vice President of the Academy representing the Medical Society of the District of Columbia.

Group Health and Accident Insurance: Members will recall that several weeks ago they received a letter from the Executive Board inquiring if they were interested in a group health and accident insurance policy. Three hundred and forty-three physicians responded, of which 304 indicated their interest; 26 were not interested; 3 were insured elsewhere; 3 were over the age limit; and 7 were not interested at the present time but requested further information regarding the policy decided upon.

The Society's interest having been determined, the Board appointed a special committee to review several group policies. The committee finally approved a policy offered by the Massachusetts Casualty Company of Boston. The Board later concurred with the committee's action.

Your Board does not want to go into too much detail in describing the policy decided upon but it does want you to know the facts not only in regard to the provisions of the policy but also the Company itself.

A careful investigation was made of the Company. It was ascertained that it was not a large organization. On the contrary, it is small, as insurance companies go. However, the Board is reliably informed that it has been well managed and its reputation is excellent.

Non-cancellable policies are difficult to purchase now because of the poor experience companies have had with this type of underwriting. Naturally, companies who still write these policies insist upon good risks. Your Board agreed with its committee that a non-cancellable policy was most desirable even though it would bar some members who were not good risks. This was one of the reasons why the Massachusetts Casualty Company's policy was chosen.

In outline, the substance of the group policy offered by the Massachusetts Casualty Company is as follows:

- "1. Loss of time due to Accident—Benefits begin the first day and are payable for *life*.
2. Loss of time due to Sickness—Benefits begin the 8th day and are payable for 52 weeks.
3. Principal sum for accidental death—\$1,000.00.
4. Cost: \$25.00 weekly income—\$40.00 Annually, \$20.00 Semi-annually, \$10.00 Quarterly. (These benefits may be doubled with corresponding increase in cost.)
5. The policy is non-cancellable to age 70.
6. At age 55, the benefits will decrease by 25% or will remain constant with an increase in payment.
7. The policy may not be ridered to eliminate recurrent disabilities nor may it be changed or altered in any way once it is issued.
8. House confinement is not required at any time, regardless of whether a doctor is on his vacation.

9. No medical or physical examination is necessary. An application is filled out and signed.

10. All claims are settled by our office here in Washington on a personal basis."

If the Society agrees with the Board that the policy here described is satisfactory, it will inform the membership generally to this effect. A representative of the Company will thereafter solicit physicians directly.

RECOMMENDATIONS OF COMMITTEES

Committee on Rehabilitation of Service Physicians:

There are many physicians in the armed services who have never been in private practice. They completed their internships and were immediately inducted into some branch of the military services. Some of them have been licensed in this jurisdiction, others have not. Some will return here and others will go elsewhere. However, the Committee on Rehabilitation of Service Physicians believes these physicians should be made to feel that they are wanted in this community, that they will be most welcome upon their return, and that the Medical Society is interested in them.

It was the Committee's recommendation to the Board that recent graduates now with the armed forces who plan to return here and who can meet the Society's membership qualifications be invited to apply for membership and be informed that their dues will be remitted for the duration of the war or one year following their discharge from military service. Your Board wholeheartedly approves of this recommendation.

Committee on Public Policy: At a meeting on February 8, 1945, the Society's Committee on Public Policy considered and acted upon the following bills:

1. The Committee reiterated its opposition to H.R. 491—a bill to prohibit experiments upon living dogs in the District of Columbia and providing a penalty for violation thereof. It voted that a communication be directed to Representative Jennings Randolph, Chairman of the House District Committee, stating the Society's reasons for opposition to this legislation.

2. It favored S. 406—a bill to provide for health programs for Government employees, except that portion of the bill in which "physician" is defined in such a manner as to permit osteopaths to participate in the program. This is a companion bill to one introduced by Representative Jennings Randolph in the House which does not contain the "physician" definition.

3. It opposed the enactment of H.R. 1626—a bill providing for the abolition of the office of coroner and for the organization of the office of medical examiner for the District of Columbia.

4. It endorsed H.R. 1391—a bill to establish a Department of National Health, and for other purposes.

It was reported that this bill had the support of the American Medical Association.

5. It approved S. 223, the so-called Tydings Hospital Bill, in principle, reaffirming the position taken last year with regard to this legislation that "all non-profit voluntary hospitals rendering service to the indigent and the near-indigent in the District of Columbia be given equal opportunity to participate and are assured equal representation in the corporate body."

The Committee sought the Board's approval of actions taken on the above legislation.

Subcommittee on Mental Health: With the approval of the Chairman of the Committee on Public Health, this Subcommittee submitted the following recommendations to the Board for approval:

1. Recommended that appropriate legislation be drafted and introduced in the Congress providing for voluntary admissions to Saint Elizabeths Hospital.

2. Took cognizance of the public interest manifested in alcoholics, agreeing on the following points:

(a) Alcoholism is a medical problem and there are many causes for it which only physicians are capable of diagnosing. The importance of the work done by psychologists, physical therapists, social workers and others is recognized but in any event, supervision of the care of alcoholics should be in the hands of the physicians.

(b) Clinics for alcoholics are desirable. However, they should be under the supervision of a psychiatrist. These clinics might act in an advisory capacity to the courts. (The Committee unanimously agreed that the patients accepted at community clinics should be those unable to pay a physician for his services.)

(c) There should be legal provisions for the commitment of alcoholics and drug addicts, as such, to some institution, private or public.

The Subcommittee requested the Board's endorsement of its position.

Subcommittee on Venereal Diseases: This subcommittee also submitted recommendations to the Board with the approval of the Chairman of the Committee on Public Health. It proposed that a substitute for Section 6 of the Communicable Disease Regulations for the District of Columbia be presented for the consideration of the District Health Officer.

Section 6 of the Regulations now reads as follows:

"No person knowing that he is suffering from any venereal infection in a form likely to be a source of infection to others shall work as a domestic servant, barber, masseur, cook, baker, or other producer or handler of food or drink, nor shall any such person be employed or permitted to work in such occupation."

The proposed substitute which the Subcommittee presents for approval reads as follows:

"Any person suffering from venereal disease in a form likely to be a source of infection must submit to treatment or be isolated. Infectious contacts reported shall be examined. If found to be a source of infection, they must submit to treatment or be isolated."

Your Board approves the above actions and recommendations of the Committee on Rehabilitation of Service Physicians, the Committee on Public Policy, the Committee on Public Health and the Subcommittees on Mental Health and Venereal Disease.

Physicians Commissioned in the United States Public Health Service: The Board voted at its last meeting held on February 26 that the dues of physicians who have been commissioned in the United States Public Health Service since this country went to war be remitted for the duration or until they are discharged from the service.

Washington Metropolitan Health Council's Health and Hospital Survey Endorsed: Members are familiar with the organization of the Washington Metropolitan Health Council, a division of the Council of Social Agencies of the District of Columbia and Vicinity. The Council recently voted to make a health and hospital survey of the Metropolitan Area. The survey will be under the direction of a committee of which Vice Admiral Ross T. McIntire, Surgeon General of the U. S. Navy, is Chairman.

Your Board endorsed the proposed survey with the reservation that the Society in no way is committed to approve the Council's recommendations following the study.

Philippine Government Seeks Society's Coöperation: At the Board's meeting on February 26, a communication received from the Honorable Jaime Hernandez, Secretary of Finance of the Commonwealth of the Philippines, was presented. Mr. Hernandez stated that Dr. John H. Trinder, a member of the Society, and Dr. Manuel Casas, one of the Filipino physicians residing in Washington, had discussed with him relief activities in the Philippines with special reference to the shortage of medical supplies. Dr. Trinder suggested that a considerable quantity of drug samples are in the hands of individual doctors. Mr. Hernandez said, "I am taking the liberty of soliciting your coöperation in the collection of samples of medicines that your members may be willing to contribute for relief purposes in the Philippines."

Your Board voted to coöperate with the Philippine Government in this matter and appointed Dr. Trinder as the Society's representative to collect samples for the purpose stated.

Election of Member of Board of Trustees of Group Hospitalization, Inc.: This is another item which should have been listed on the agenda sent you for this meeting.

In a communication dated February 20, 1945, President Greear was advised that in accordance with the By-laws of Group Hospitalization, Inc., the Medical Society of the District of Columbia elects one member of the Board of Trustees of Group Hospitalization, Inc., annually. This year the Society elects a successor to one of the following members whose term expires:

General Frank T. Hines

Frank R. Jelleff

Sidney F. Taliaferro

Your Board voted unanimously to recommend that Mr. Frank R. Jelleff be elected to succeed himself since the medical profession is now represented by its full quota of physicians on the Board of Trustees of Group Hospitalization, Inc.

Davidson Lecture: The special committee of the Board appointed to review the manuscripts submitted in the competition held in connection with the DAVIDSON LECTURE is confident that many excellent contributions will be received before July 1, 1945, when they must be in the hands of the Secretary. The LECTURE will be given on October 17, 1945.

It will be of interest to you to know that the committee has ruled that a physician in the armed forces may participate even though he is not able to deliver his paper in person should it be chosen. In this event, a physician of his choice would read it for him.

Conclusion: As some of you know, Lt. Colonel James N. Greear, President of the Society, has been ordered overseas. Colonel Greear has been a faithful attendant at meetings of the Board but has not found it possible to preside at scientific meetings. This has been done for him by our First Vice President, Dr. William M. Ballinger.

In view of Colonel Greear's departure all of the President's duties for the remainder of his term will fall to Dr. Ballinger. Chapter V, Article I, Section 4 of the Constitution and By-laws provides, "The Vice Presidents shall, in order of their rank, assume the duties of the President during his absence or inability to act." Dr. Ballinger has indicated his willingness to carry on for his good friend, Colonel Greear, during his absence with the armed forces. Your Board is sure that you will agree that the President's responsibilities are in good hands.

Respectfully submitted,

HENRY R. SCHREIBER, M.D., *Chairman*

WILLIAM EARL CLARK, M.D.

COURSEN B. CONKLIN, M.D.

JAMES N. GREEAR, M.D.

WILLIAM P. HERBST, M.D.

A. M. MACDONALD, M.D.

FRED R. SANDERSON, M.D.

THEODORE WIPRUD, *Secretary*

NOMINATIONS

The following nominations for elective offices were presented by the Nominating Committee in the order shown at the business meeting of the Medical Society on March 7, 1945:

For President-elect

William Parker Herbst, Jr.

Harry Arnold H. McNitt

For First Vice President

Fred A. J. Geier

R. Lomax Wells

For Second Vice President

Dorothy S. Jaeger

Agnes Louise McNutt

For Member of Executive Board

William M. Ballinger

Frank J. Eichenlaub

For Member of Board of Censors

Harry F. Dowling

Don Johnson

For Delegate to American Medical Association

Coursen B. Conklin

Frank D. Costenbader

For Alternate Delegate to American Medical Association

Arch L. Riddick

Edward J. Stieglitz

No additional nominations were made from the floor. Elections to the above offices will be held at the annual business meeting, May 2, 1945.

MEETINGS

Wednesday, May 2

ANNUAL BUSINESS MEETING

Wednesday, May 9

PREVENTIVE MEDICINE (15 min.): "Periodic Health Inventories," EDWARD J. STIEGLITZ, M.D., F.A.C.P., Washington.

The Washington Academy of Surgery will sponsor the following program:

"The Problem of Regional Ileitis with Remarks on the Surgical Therapy of Ulcerative Colitis," JOHN H. GARLOCK, M.D., F.A.C.S., Clinical Professor of Surgery, New York Post-Graduate Medical School and Hospital.

Wednesday, May 16

PREVENTIVE MEDICINE (15 min.): "Preventive Nutrition," LT. COMDR. C. M. McCAY, U.S.N.R., in charge of Nutrition Studies, Naval Medical Research Laboratory, Bethesda, Md.

"The Problem of False Serologic Tests for Syphilis," CHARLES R. L. HALLEY, M.D., Clinical Professor of Medicine, George Washington University School of Medicine.

CANCER AND OTHER MALIGNANT TUMORS IN THE DISTRICT OF COLUMBIA, 1880-1944

JOSEPH B. IRVINE

Director, Bureau of Vital Statistics, District Health Department

In the year 1880 when the population of the District of Columbia was 180,349 the death rate per 100,000 population from cancer was 38.0. In the year 1944 the death rate from cancer was 131.3, an increase of 93.3 per 100,000 population. The number of persons who died from cancer and other malignant tumors in 1880 was 69 (56 white, 13 colored). Last year the deaths were as follows: white 884, colored 298, total 1,182. The proportion of colored to the total population in 1880 was about 34 per cent, while the proportion of colored cancer deaths to all cancer deaths was 18.8 per cent. In 1944 the proportion of colored to the total population was about 28 per cent and the percentage of colored deaths to total cancer deaths was 25.2. This would indicate a decided increase among the colored as compared with the white. However, it should be borne in mind that this apparent difference may be due in part to better diagnoses.

Attention is directed to another point to be considered in comparing the cancer death rates of the white and colored races, namely, cancer is essentially a disease of the mature and the aged and not a disease of youth. It is a well known fact that the average age at death of white persons, both male and female, is considerably higher than that of the colored. This is made clear by the following statement. The average age at death of all persons who died in the District of Columbia during the calendar year 1943 was 52 years and 2 months. The average age of the male white was 54 years, 7 months; female white, 59 years, 4 months; male colored, 42 years, 11 months; and female colored, 44 years, 5 months. Sixty-six per cent of all persons who died of cancer had passed their fifty-fifth year of age. It is, therefore, apparent that a large proportion of the colored population die of other causes before reaching the age of greatest susceptibility to cancer and other malignant tumors. Among the white, 69 per cent of the cancer deaths are persons who have reached the fifty-fifth year, while among the colored only 56 per cent have attained that age.

The highest death rate from cancer during the

period 1880-1944 was in the year 1939 when the rate was 156.5. Since then the trend has been downward, until the present rate of 131.3 for the year 1944. This is virtually on a par with the year 1935 and except for that year and 1942 is the lowest rate since 1929.

The following table shows the number of deaths and the death rate from cancer in the intervening decennial years 1880-1930 and also 1935, 1940 and 1944 in the District of Columbia.

Number of Deaths, D. C.				D. C. Death Rate per 100,000 population			U. S. Reg. Area
Year	White	Colored	Total	White	Colored	Total	
1880	56	13	69	47.	21.	38.	—
1890	85	36	121	51.	44.	49.	—
1900	147	71	218	72.	78.	74.	63.0
1910	239	54	293	95.3	55.3	84.1	76.2
1920	339	78	417	103.7	70.9	95.3	83.2
1930	508	156	664	143.2	118.1	136.4	97.2
1935	593	186	779	137.3	114.8	131.1	108.2
1940	779	227	1,006	164.4	119.9	151.7	120.3
1944	884	298	1,182	137.4	116.2	131.3	—

Cancer Death Rates by Race in Selected Cities—1943			
	White	Colored	Total
Baltimore, Md.	161.8	109.2	151.7
Cincinnati, Ohio	224.9	114.4	211.3
Cleveland, Ohio	172.5	122.5	167.7
Detroit, Michigan	105.4	71.8	102.3
Indianapolis, Indiana	171.0	137.9	167.0
Kansas City, Missouri	156.2	147.6	155.3
Los Angeles, California	158.1	119.6	144.6
Newark, New Jersey	158.4	66.7	148.9
New Orleans, Louisiana	154.1	155.5	154.5
Philadelphia, Penn.	195.2	147.0	188.9
Washington, D. C.	145.5	101.4	132.9
Median—above cities	158.4	119.6	154.5

None of the cities listed has a total population of less than 400,000 nor less than 42,000 colored.

The city with the highest rate for white is Cincinnati, for colored, New Orleans, and for all races, Cincinnati. New Orleans is the only city reporting the rate for colored higher than that for the white race.

Washington, D. C. is well below the median rate in white, colored and total. The relative position is second best for white, third for colored and second for total. The best rate for white cancer deaths is in

CANCER AND OTHER MALIGNANT GROWTHS
Deaths and Death Rates

1925-1944

District of Columbia

Year	Number of Deaths		Total	Death Rate per 100,000		population
	White	Colored		White	Colored	Total
1925	433	122	555	114.5	102.0	111.1
1926	430	146	576	109.1	109.2	109.1
1927	480	125	605	118.9	91.8	112.0
1928	484	124	608	114.0	97.2	110.1
1929	489	147	636	115.2	115.2	115.2
1930	508	156	664	143.2	118.1	136.4
1931	518	143	661	145.5	105.9	154.6
1932	558	164	722	156.3	120.6	146.5
1933	556	185	741	155.3	135.0	149.6
1934	601	160	761	147.6	104.6	135.9
1935	593	186	779	137.3	114.8	131.1
1936	667	191	858	148.8	113.0	138.6
1937	695	184	879	152.5	107.5	140.2
1938	667	204	871	146.3	119.2	138.9
1939	747	270	1,017	157.9	152.3	156.5
1940	779	227	1,006	164.4	119.9	151.7
1941	782	278	1,060	145.8	130.1	141.3
1942	829	279	1,108	136.7	115.4	130.7
1943	936	260	1,196	145.5	101.4	132.9
1944	884	298	1,182	137.4	116.2	131.3

DEATHS DUE TO CANCER, BY AGE GROUPS IN THE DISTRICT
OF COLUMBIA, 1943

	Sex	Total	White	Colored
Under 1 year	M	—	—	—
	F	—	—	—
1-4	M	1	—	1
	F	1	1	—
5-14	M	1	—	1
	F	1	1	—
15-24	M	10	10	—
	F	3	2	1
25-44	M	71	57	14
	F	70	41	29
45-64	M	249	187	62
	F	276	201	75
65+	M	252	211	41
	F	261	224	37
Total	M	584	465	119
	F	612	470	142
	All	1196	935	261

DEATHS FROM CANCER IN THE DISTRICT OF COLUMBIA—1943

SITE OF CANCER	WHITE		COLORED		TOTAL	
	Male	Female	Male	Female	Male	Female
Buccal cavity and pharynx.....	21	6	3	1	24	7
Lip.....	2	0	0	0	2	0
Tongue.....	11	1	3	0	14	1
Mouth.....	2	1	0	0	2	1
Jaw-bone.....	1	1	0	0	1	1
Pharynx.....	4	3	0	1	4	4
Other.....	1	0	0	0	1	0
Digestive organs and peritoneum.....	190	168	64	61	254	229
Esophagus.....	16	0	5	2	21	2
Stomach.....	43	33	26	23	69	56
Duodenum.....	6	0	1	0	7	0
Rectum and anus.....	17	19	4	4	21	23
Intestines.....	62	56	12	15	74	71
Liver and biliary passages.....	18	34	11	6	29	40
Pancreas.....	20	21	4	5	24	26
Mesentery and peritoneum.....	2	2	0	1	2	3
Other.....	6	3	1	5	7	8
Respiratory System....	82	22	12	6	94	28
Larynx.....	10	0	2	0	12	0
Trachea.....	1	0	0	0	1	0
Bronchus.....	30	4	4	1	34	5
Lung.....	37	16	6	5	43	21
Pleura.....	1	2	0	0	1	2
Mediastinum and unspecified.....	3	0	0	0	3	0
Genitourinary.....	90	136	24	46	114	182
Uterus.....	0	94	0	37	0	131
Ovary.....	0	23	0	3	0	26
Other female.....	0	3	0	3	0	6
Prostate.....	47	0	16	0	63	0
Testes.....	8	0	0	0	8	0
Kidneys.....	10	7	2	0	12	7
Bladder.....	22	8	6	3	28	11
Other.....	3	1	0	0	3	1
Breast.....	0	90	1	18	1	108
Skin.....	14	4	0	1	14	5
Brain.....	9	4	1	1	10	5
Bones.....	6	4	2	2	8	6

DEATHS FROM CANCER IN THE DISTRICT OF COLUMBIA—
1943—Continued

SITE OF CANCER	WHITE		COLORED		TOTAL	
	Male	Female	Male	Female	Male	Female
Other and unspecified organs	53	36	12	6	65	42
Totals.....	465	470	119	142	584	612

DISTRICT OF COLUMBIA, 1944; CAUSE OF DEATH: CANCER
AND OTHER MALIGNANT GROWTHS

MONTH	WHITE		COLORED		TOTAL
January	35	27	9	11	82
February	37	36	6	11	90
March.....	37	34	9	16	96
April	34	41	10	14	99
May.....	37	31	12	14	94
June.....	29	52	9	8	98
July.....	28	39	13	16	96
August.....	44	28	14	18	104
September.....	37	35	15	14	101
October.....	39	46	15	13	113
November.....	48	41	11	17	117
December.....	31	38	10	13	92
Total.....	436	448	133	165	1182

Detroit, for colored deaths in Newark, N. J., and for all races in Detroit.

The preceding tables list cancer deaths and death rates in the District of Columbia by color and sex for the years 1925 to and including 1944. Also another table shows cancer deaths by month, color and sex, 1944.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the business session, February 14, 1945:

Active Members

Caroline Frances Burbeau, 1954 Columbia Road, N.W.
Harry Albert Giltner, 1312 Shepherd Street, N.W.
Joseph Patrick Kenrick, 7942 Wisconsin Ave., Bethesda, Md.
Emmett P. Madigan, 1st Lt., M.C., A.U.S., AAF Station Hospital, Biggs Field, El Paso, Texas
Stephen A. McCarthy, 1743 Shepherd Street, N.W.
Maurice Mensh, 1710 Rhode Island Ave., N.W.

Associate Members

Donald Henry Glew, D.D.S., 1150 Connecticut Ave., N.W.
Olive Pippy, 331 Flower Ave., Takoma Park, Md.
Rebecka Schneider, 2929 Connecticut Ave., N.W.

The following applicants for membership were duly elected to membership at the business session, March 14, 1945:

Active Members

Beatrice Bishop Berle, 4000 Nebraska Ave., N.W.
Edward Charles Durkin, 1923 Eye St., N.W.
Charles William Ordman, 1150 Connecticut Ave., N.W.

Associate Members

Milton Irwin Roemer, 2701 31st Street, S.E.
Guy R. Stoddard, 456A 41st St., Miami Beach, Fla.

The following applicants for membership will be voted on at the business meeting, May 2, 1945:

For Active Membership

Arthur S. Bauer, Long Island College—1927
Karl H. Langenstrass, University of Jena, Germany—1917
Henry Simmons Murphy, Queens University, Kingston, Canada—1928

For Associate Membership

John Philip Clum, George Washington University—1937
Leo Ignatius Donovan, Georgetown University—1938
Elizabeth Adams-Koppel, College of Medical Evangelists, Los Angeles, Calif.—1942
Joseph S. Lawrence, Johns Hopkins University—1916

War Section

NEWS ABOUT SERVICE PHYSICIANS

Major General Normal T. Kirk, Surgeon General of the Army, is back in Washington after six weeks in the Pacific Theater of Operations, where he and his party inspected all phases of the Medical Department's operation.

Dr. William Calhoun Stirling, Honorary Consultant to the Surgeon General of the Navy, returned February 28 from a month's inspection tour. In the course of his tour he traveled 10,000 miles by plane and visited Naval hospitals in all the large cities of the United States, including Chicago, Minneapolis, Spokane, Los Angeles, Phoenix, Dallas, New Orleans, Atlanta and Richmond. He addressed the hospital staff at each place visited on the subject of rehabilitation.

Major Henry B. Gwynn of the Reconditioning Consultants Division, Office of The Surgeon General, was one of a group of officers representing various divisions of The Surgeon General's Office who inspected the following Army general hospitals: Ashford General Hospital, White Sulphur Springs, West Va.; Thayer General Hospital, Nashville, Tenn.; Northington General Hospital, Tuscaloosa, Ala.; Lawson General Hospital, Atlanta, Ga.; Finney General Hospital, Thomasville, Ga.; Welsh Convalescent Hospital, Daytona Beach, Fla.; the Army General and Convalescent Hospital, Camp Butner, Durham, N. C.; and Moore General Hospital, Swannanoa, N. C.

Captain Irvin Hantman presented a paper on "Secretory Otitis Media; Experiences with 125 Cases Seen in the Army," at the Regional Professional Medical Meeting, held March 8, at the Battey General Hospital, Rome, Ga.

A special Combat Badge has been authorized for Medical Department personnel who daily share with the infantry the hazards and hardships of combat.



Medical Combat Badge

Made of silver, the badge is elliptical in shape with the caduceus and the Geneva Cross superimposed on a litter surrounded by a wreath of oak leaves. It is to be worn on the left breast above decorations and service ribbons.

The badge was established in recognition of "the important role being performed by medical personnel on duty with infantry units, especially infantry battalions." Enlisted and officer personnel below field grade (major) and regimental surgeons regardless of rank are eligible for the badge if they have seen combat service with the infantry since December 7, 1941.

LETTERS FROM MEMBERS IN THE SERVICES

From Captain George W. Reeves, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: I have read with interest in the *Annals* and the *J. A. M. A.* the articles and comments and editorials on what will be done to help the returning service physician, but they all seem vague. So here are some concrete questions.

1. To what degree will the returning physician be given credit and recognition for what he may have learned in the Army? Maybe that needs a little explanation. I had what was considered, I guess, a bastard practice; I wasn't a "specialist" but had rather prolonged training in Ob. and Gyn.; I was in practice with a general surgeon, and did a fair amount of work with and for him, yet I maintained a general practice.

Since being in the Army I have had a peculiar setup—I have been in China, in a small hospital (only four medical officers) yet doing a large amount of surgery because we evacuate casualties to a Chinese convalescent hospital. We have no unit behind us to evacuate anything to, even the work that requires a competent neurosurgeon or orthopedist, or plastic, or maxillofacial surgeon. Consequently we have had to do it all, if it was done. I won't say that all of the results have been excellent but they have been good—surprisingly so. Now, if I should return to D. C., will I be allowed to do what work I feel I am *well* qualified to do? I don't mean everything—there are many jobs for the specialist, but there are also many that I feel well qualified to do that I wasn't before. Will I be allowed

to plate a bone, or resect an intestine, or will the hospitals say "no"?

2. About hospital staff appointments. If a physician was a staff physician at a hospital before entering the Army, is he given seniority rights while in the service, or is a physician who remains at home placed above him if a vacancy exists?

3. Have the hospitals themselves any plan to help returning service physicians when he returns? For instance, I am on the staff at Columbia, as an assistant. I have been in the Army nearly 3 years, and of course haven't delivered a baby, nor done any pelvic surgery. When I return will the hospital give me a chance to refresh myself in the delivery and operating room, and not stick me down in the O.P.D. to take blood pressures and routinely examine patients?

I guess that is all—do other people ask foolish questions like these?

As for myself, I am well. Our work has been quite good here. Was mixed up in the Salween campaign—the medical work was not too difficult but the terrain was terrible—everything went by pack animals, and the personnel by foot. I spent 31 actual days on mountain trails chasing pack mules, fording streams, etc.—it was hard, but it was fun, especially to look back on. Our unit was fortunate enough to get a commendation for its work, and we felt pleased, as there were only 3 units so honored. We are now not actually in an active zone, but our work has been heavy as hospitals are few and far between in China, and there are many troops in training here, consequently many accidents and injuries besides routine work.

Hope to be in D. C. before the year is out, and you may be sure that I will drop in to see you when I get there.

From Major Philip A. Stebbing, c/o Postmaster, San Francisco, Cal.:

Dear Mr. Wiprud: I left Frisco with the 39th Gen. Hosp., which is an affiliated unit, from New Haven, in November, 1942. How I came to be with them is too long a story to retail here. We spent over two years in New Zealand, and just moved up to the Marianas in January of this year. In N. Z. we had a very beautiful hospital. It was built for us by the N. Z. Dept. of Public Works, under reverse Lend-lease, on the general ground plan of the cantonment type hospitals in the U. S., but the buildings presented a much more finished appearance, inside and out. It was located in a city park, and our own men did some landscaping, planting of flowers and lawns, etc., so that it was the show-place of the South Pacific. We were quite busy during the Solomons campaigns, but towards the end of 1944, our business began to taper off, so that we were ready for a move. The climate was delightful, and the people the very soul of hospitality. While I was there, I was on the lookout for someone from Washington, but the only one I found was John Cavanagh, a classmate of mine, who is well known to you. He came in on a hospital ship, bringing us patients, and I was very glad to see him.

Our hospital here is not yet completed, but nearly so, and in the meantime I have been acting as Battalion Surgeon for an Ordnance Bn., while their medical officer is taking a refresher course in one of the other hospitals on the island. It is my first experience in the field, and his first experience in an Army hospital, and we are both enjoying the experience.

From 1st Lt. Simon C. Weiner, c/o Postmaster, San Francisco, Cal.:

Dear Mr. Wiprud: It has been a long time since I have heard any medical news from Washington. For a short time after entering the service I did receive your monthly magazine but when I left the states you seemed to have lost track of me. I would so very much like to have your magazine to be sent to me. Since leaving the states I have had many thrilling and exciting experiences. I have been in New Guinea, New Britain, and other islands on my way to the Philippines. This has been my first sight of civilization in six months. I had the privilege of seeing the imprisoned American internees and all they had to show was their wonderful will power and determination. There was nothing left to them but skin and bones. I have seen beautiful cities destroyed, natives starving, inhuman cruelties inflicted, and I am very happy to be part of the liberation forces. I pray that this war will soon be over and I can again meet with you.

From Lt. Colonel Walter Stokes, Camp Luna, Las Vegas, N. M.:

Dear Ted: Like everyone else who has been away so long I deeply appreciate your news letters and the personal items in the "Annals."

It is my hope that before long I may get an overseas assignment that would carry me over a wide area and if I get this mission I am looking forward to meeting some of our friends in overseas medical service.

From Lt. Comdr. Perry W. Gard, c/o Fleet Post Office, San Francisco, Cal.:

Dear Ted: I have seen no one from home out this way but having been stationed at a fair number of Air Stations I can't say that I am at a loss for friendship. This assignment is very interesting as it represents the final application of what we worked hard at Pensacola to get. I am Senior Medical Officer here as well as Senior Flight Surgeon. Our job has been a very pleasant one and with the food splendid, the living quarters all that could be reasonably expected, and the officers a truly splendid crowd of men, I have very little ground for complaint. Naturally I can tell you very little of where we are, what we are doing, etc., especially since I am Chief Censor! But rest assured that there is always time in each day for thoughts of life back in D. C. and for wondering what will happen when we get the word to put these clothes back into moth balls. If you are interested in the subject of Naval Aviation (and that it is the cream of the crop I am sure Tokyo will testify), you should be sure and see the picture "Fighting Lady"; it is a splendid job and very true to the facts.

From Lt. Colonel Frederick D. Suttentfield, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: If you see fit, there is no objection whatever to your reproducing General Eddy's letter in the *Annals*. It has been cleared properly for press release. You are right in that I was proud. My outfit hit the Normandy beachhead new and untried. I didn't wade ashore after a night at anchorage in which Jerry gave us all hell from the air. Rather, I was physically carried ashore in the arms of an

American soldier (God bless him; he had on waist-high boots and I had on shoes and leggings!). In fact, my companies were given me as we rolled toward the front. We poised a few days to assemble. And to my surprise and joy, my battalion was given the honor of supporting the spearhead corps of the Avranches break-through and the Third Army dash across France.

I believe I wrote you recently that my battalion was the first medical unit in Third Army to receive the citation and award of the Meritorious Service Unit Plaque—the highest unit award we can achieve. Of this I am deeply proud, for it brings both individual and group pride to the officers and men of my command. They worked for it both individually and as a big team. They deserved it. They got it!

From Major Darrell C. Crain, c/o Postmaster, San Francisco, Cal.:

Dear Ted: Since it has been about one year since I gave you some data on my whereabouts I suppose it is time that I produced another account of my good behavior.

Last time I wrote I believe that I was in the Northern Territory of Australia some 70 miles south of Darwin at a little bush camp known as Adelaide River. Well, since that day I have gotten around quite a bit and have seen my share of the SW Pacific. First of all, in March I was transferred out of my unit and into Headquarters. I arrived in Brisbane just in time to attend a farewell party for Henry Gwynn. Tell him when you see him that he left just in time; if he thought the move from Sydney to Brisbane was bad he should have been in on the one from Brisbane to Hollandia.

Since this camp is supposed to be only temporary and used only until we can get to Manila nothing has been done to make the place have even a semblance of livableness. Tents are piled one on top of another, are pitched directly on the poles (the boys who have lived in a tent very long can describe the "tent frame" which makes the place cool enough to bear), we have four shower heads for several hundred officers and water being scarce is turned on only certain periods a day, all offices are in tents with dirt floors and the mess hall is one large open tent with not enough tableware to go round so that eating is in two shifts. In short, this is a field office that looks like something Teddy Roosevelt might have had at the foot of San Juan Hill.

Fortunately, the civilian population has provided us with the few comforts we do enjoy. We have a boy who comes in the morning and makes the "beds"—army cots, sweeps the place out, shines our shoes and such other little items calculated to make the life of the officers in the Tropics one long vacation. It is a circus to see the women coming into camp in the evening with huge bundles of laundry balanced on their heads. It is even more of a circus to see them out in a swamp or creek beating the dirt out of the clothes with paddles. No one imagines the clothes will last long with such a shellacking and the thing I could never understand is how they can get the clothes clean when it always looks like the water they pick to wash them in is muddy and brown before they start. However, the clothes look good when they are delivered and that is all that matters.

The houses here that the Filipinos live in are simply out of this world. Made of thatched reeds they are built over the

swamps on stilts and the majority look as though they are maintained in the Pisa Tower position by the grace of God and in defiance of the laws of gravity. However, no matter how poor the hut it seems to have a Singer sewing machine and I now know why that Singer agent used to be so anxious for us to get a new model and trade him in the old one.

Believe me the people use them too and it is amazing that no matter how rainy and muddy or how hot and dusty it may be the girls all look starched and clean whenever they are on the streets. Their clothes too are surprisingly well tailored. Most interesting clothes are the ones the girls have made out of salvaged parachutes. Being fond of bright colors one sees all shades of red, green, yellow.

The boys all like to wear G-I clothes particularly the hats with insignia. All in all this place is most interesting and I would not have missed it for the world. However, once I see Manila (or what the Japs have left of it), I will sure be ready to hit the trail for home.

Well, Ted, tell all the boys "Hello." You may be seeing Ivy Pelzman before too long. I would not be surprised either to see Eddie Grass' name on the rotation list. His division did a swell job in these islands. Aside from that I do not know any gossip of the Washington gang so shall sign off (for another year maybe).

From Major William A. Ryon, c/o Postmaster, New York, N. Y.:

My dear Mr. Wiprud: It has been a long time since I wrote you last, during which, both for myself and the world at large, many things have been happening. In my last letter to you, I was doing some good old G. I. complaining, because I was once more out of the practice of medicine and back into the training business, as a battalion commander. I also had a few complaining remarks, because I had spent two years in the states, without an apparent chance for overseas service. The gods of fortune lent a willing ear to my cries, however, and here I am.

First, I was assigned as executive officer to the newly activated 224th General Hospital at Fort Lewis, Washington. This was commanded by an old acquaintance of mine, Lt. Col. William S. Love, formerly of Baltimore. Things moved very rapidly after that. The outfit was activated on Oct. 15, and on Nov. 25 we were on our way east to catch the boat.

The trip over was very uneventful, and we enjoyed three weeks in an old English castle. I should say we enjoyed it, except for the lack of heat and plumbing. We didn't tarry long in England, though, and we were soon off for France.

Many things happened in the next few weeks, for which there is not time and space to write. However, let me say those first four weeks in France were pips. We were in snow and mud up to the waist line, and not once did we get out of those clothes that we landed in. I can well imagine that we were a sorry looking, and highly smelly outfit.

After a month of it, we had a lucky break, and took over a very modern French hospital to operate. It is a tremendous place, with three large buildings, any one of which is larger than any hospital that we have in Washington. In addition to the main buildings, there are many smaller ones, including a chateau, in which I have been making my quarters. Our present setup is certainly a far cry from our experiences of the first month.

I had a new experience, several weeks ago. Up until then I had never had the luck to run into a single M. D. from Washington since coming into the service, except for my association with Ritchie, who entered at Camp Pickett with me. While sitting at my desk a few weeks ago, who should barge into my office but Clayton Hixson. Lt. Col. Hixson is in command of a Station Hospital, located not too far away from us. You can believe me, running into folks from back home, over on this side of the world, is just about the nicest thing

that can happen. I was down to visit him yesterday, and as you would expect of him, he has a splendid organization. One of our topics of conversation was the enjoyment we receive from your periodic letters.

Speaking of letters, I have not received any communications from the Society for some time, but that is explainable by my frequent moves in the past six months. I would certainly enjoy hearing some news from the home front in the medical department.

SICK ABSENTEEISM AND MEDICAL CERTIFICATES*

The present critical need of manpower for increased war production calls for more effort to be directed toward reduction of unnecessary absenteeism and labor turnover. Among the many factors bearing on this problem is the relation between private physicians and industrial physicians. A statement recently prepared on this subject by the Safety and Security Division, Office of the Chief of Ordnance, Army Service Forces, directed toward industrial physicians in Ordnance plants, has been called to our attention because of its applicability to all plant physicians and cooperating private physicians.

This statement says in part, "To minimize absenteeism alleged to sickness and terminations attributed to ill health, the closest possible cooperation should be maintained between plant physicians and private physicians in nearby communities. Private physicians often have no accurate information concerning health hazards associated with their patients' jobs in Ordnance plants and the generally satisfactory medical and engineering measures taken for their control, and are often at a loss as to how to advise their patients regarding complaints related to work. Likewise, private physicians are not generally aware of the information concerning their patients, available from the plant physician in connection with past examinations, blood tests, X-ray findings, and other diagnostic aids."

The related problem of medical certification of illness has also been brought to our attention as a matter that should be considered by the State In-

dustrial Hygiene Divisions. This subject was discussed in an editorial entitled, "Medical Certificates and War Production," published in the *Journal of the American Medical Association*, November 11, 1944. The private physician's responsibility is presented in this editorial as follows:

"The government and its contracting agents customarily require medical certificates to cover an absenteeism alleged to illness or a labor termination attributed to reasons of health. The medical profession is then put under pressure by thoughtless persons who see little harm in collecting disability benefits or in obtaining better jobs on pretext of illness. They fail to see the cumulative results of hundreds of thousands of such acts on critical war production. Responsibility rests squarely on the physician to act as prosecutor, defense attorney and judge before issuing such a certificate. He fails himself, his profession and the war effort if certificates are issued without due cause."

Traditionally, the doctor has been called upon to champion and be an advocate of his patient. In the main, the patient has been the one who employed him and he has instinctively defended the patient against any or all groups having impersonal interests. The doctor is called upon to certify to this and to that. He must certify birth and death; the occurrence of contagious disease; the health of food handlers; and the freedom from disease of candidates for marriage. Health and accident policies depend to an appreciable extent on the knowledge and integrity of practicing physicians. Compensation statutes require medical judgments as bases to support legal judgments. One easily understands why the busy doctor labels all certification a "chore." It is true that to refuse to sign any statement his patient requests, the physician risks an irate individual, but one wonders what degree of confidence and respect

* Reprinted from *Industrial Hygiene News Letter*, December 1944, issued by The Industrial Hygiene Division, U. S. Public Health Service.

On The Home Front

The American College of Chest Physicians has cancelled its annual meeting scheduled to be held at Philadelphia in June, 1945. The Executive Council of the College voted to hold a business meeting of the Board of Regents at Chicago, June 17.

The Eighth Annual Postgraduate Course in Ocular Surgery, Pathology and Orthoptics will be held at the George Washington University School of Medicine, May 28 through June 2, 1945. Registration for the course is limited to 30. The fee is \$150, with \$50 payable with registration and the remainder payable on matriculation. Further information may be secured from the Secretary, Miss Louisa Wells, 927 17th Street, N. W., Washington 6, D. C.

The following instructors will present the course:

SURGERY: Drs. Ernest Sheppard, E. Leonard Goodman, Ronald A. Cox, Richard W. Wilkinson, Sterling Bockoven, C. R. Naples and J. B. Peebles (U.S.P.H.S.).

PATHOLOGY: Colonel J. E. Ash, M.C., U.S.A., Director of Army Institute of Pathology; Captain Joyce Morris, M.C., U.S.A.; Helenor Campbell Wilder; Lawrence Ambrogio.

ORTHOPTICS AND OCULAR MOTILITY: Dr. Ernest Sheppard, Dr. Frank D. Costenbader, Louisa Wells, Mary E. Kramer, Dorothy R. Bair, Mildred Brown and Alice L. McPhail.

The art contest sponsored by **Mead Johnson & Company** has not been cancelled although there will be no annual exhibit this year of the American Physicians' Art Association, due to the cancellation of the annual session of the American Medical Association. The subject of the contest is "Courage and Devotion Beyond the Call of Duty" (on the part of physicians). Prizes amounting to \$34,000 will be awarded. Full details may be secured by writing Dr. Francis H. Redewill, Secretary, American Physicians' Art Association, Flood Building, San Francisco, Calif., or Mead Johnson & Company, Evansville, Indiana.

CALENDAR OF MEETINGS

March 1	Section on Neurology and Psychiatry
March 3	Section on Pathology and Laboratory Medicine
March 5	Subcommittee on Maternal Welfare
March 6	Board of Censors
March 7	Business Meeting of Society
March 9	Subcommittee on Interns and Residents, Procurement and Assignment Committee
March 14	Scientific Meeting of Society Special Building Committee
March 15	Section on Pediatrics
March 20	Committee on Postgraduate Education
March 26	Executive Board
March 28	Scientific Meeting of Society

The Section on Pediatrics met March 15 in the Society's Library. Miss Patricia Morse, License Officer, Board of Public Welfare, addressed the Section on "Interpretation of the New Adoption Law."

The Section on Neurology and Psychiatry presented the following program, April 5, in the Society's Library: "Neostigmine Therapy of Neuromuscular Dysfunction," Dr. Herman Kabat, Senior Assistant Sanitarian (Reserve), U. S. Public Health Service; "Problems in Training and Rehabilitation," Lt. Colonel Henry W. Brosin, M.C., A.U.S., Psychiatric Consultant, Third Service Command.

The George Washington University Medical Society held its fifth meeting, March 17. Dr. E. C. Hamblen, Clinical Professor of Endocrinology, Duke University School of Medicine, spoke on "The Use and Abuse of the Endocrines." Discussion of the paper was led by Major Laman A. Gray, M.C., U.S.A., of Walter Reed General Hospital,

and Lt. Robert P. McCombs, M.C., U.S.N.R., of the U. S. Naval Hospital, Bethesda, Md.

The Clinico-Pathological Society met in the office of Dr. Arthur C. Christie, March 6, for the regular meeting. The following program was presented: "Meningococcus Infections in Soldiers," Lt. Colonel Worth B. Daniels; "Penicillin in Mastoid Infections," Dr. William H. Jenkins.

In the March issue of the ANNALS there appeared a list of physicians representing the Medical Society as members of **Health Security Administration**. Three additional members of the Society should have been mentioned, Dr. Walter A. Bloedorn, one of the two representatives of George Washington University Hospital, and Drs. William M. Ballinger and Watson W. Eldridge, representatives of the Public-at-Large.

The 1945 Kober Foundation Lecture was delivered by **Captain Lloyd R. Newhouser, U.S.N.**, formerly on the staff of the Naval Medical School, Bethesda, Md., on the subject, "The Role of Whole Blood Plasma and Plasma Fractions in War Medicine." The Lecture was held at Gaston Hall, Georgetown University, on March 28, the birth date of the late Dr. George M. Kober, for many years Dean of the Georgetown Medical School and founder of the Lecture.

Announcement of the award, which carries an honorarium of \$500, was made by the Very Rev. Lawrence C. Gorman, S.J., President of Georgetown University, who stated the selection had been made this year by the Association of Military Surgeons of the United States. Vice Admiral Ross T. McIntire, Surgeon General of the Navy, presided.

Captain Newhouser served in the Army in World War I. He was graduated from the Indiana University School of Medicine and entered the Naval Medical Corps in 1924, serving his internship at the Philadelphia Naval Hospital. He was appointed head of the biochemistry department at the Naval Medical School in 1939 and the next year began his work with plasma in conjunction with the Army Medical Corps. Since 1940 he has had charge of the blood substitute and penicillin program for the Naval Medical Corps. Recently he was detached from

the Naval Medical School and now is the prospective Senior Medical Officer of the *U.S.S. Consolation*, one of the new hospital ships to be commissioned in the near future.

The Washington Metropolitan Health Council sponsored the first of a series of public forums on the subject of "Mental Health in Wartime," March 21, in the auditorium of the Chamber of Commerce of the United States. Eugene Meyer, Chairman of the National Committee for Mental Hygiene, presided. Colonel William C. Menninger, Director of the Neuropsychiatry Division, U. S. Army, was the principal speaker. Dr. George C. Ruhland outlined Washington's new mental hygiene program. A discussion and question period which followed these talks was led by Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital. More than eight hundred persons were in attendance.

A portion of the program was rebroadcast by transcription over Station WINX, March 26.

The Washington, D. C. Office of the Division of Nurse Education, U. S. Public Health Service, was officially opened in the Dupont Circle Building, Room 426, on February 15, 1945. This office will furnish consultation service to participating schools of nursing in Maryland, Virginia, West Virginia, North Carolina and Washington, D. C.

Mr. Leo G. Schmelzer, of Madison, Wisconsin, has been appointed Superintendent of **George Washington University Hospital**, effective March 15. He will supervise the building and equipment of the new Hospital and will assist Dr. Walter A. Bloedorn, Dean of the Medical School and Medical Director of the Hospital. For the past ten years Mr. Schmelzer has been Administrator of the Wisconsin State General Hospital, the Orthopedic Hospital for Children and the Student Infirmary at Madison, Wisconsin. During that period he was also Chairman of the Committee on Architectural Standards for Hospitals of the American Hospital Association, and Secretary-Treasurer of the University Hospital Executives Council of the Midwest.

The Coördinating Council of the Washington Metropolitan Health Council met March 20 at the Chamber of Commerce of the United States. The

resignation of B. M. McKelway from the Executive Committee was accepted with the understanding that he would remain a member of the Council. Four new members were elected to the Executive Committee, bringing the total number of elected members to 12. The new members are Dr. Ralph C. Williams, Assistant Surgeon General of the U. S. Public Health Service; Dr. George C. Ruhland, District Health Officer; Miss Gertrude Bowling, Executive Secretary of the Instructive Visiting Nurse Society; and Frederick M. Bradley, attorney.

Judge Fay L. Bentley, who was reelected Chairman of the District Chapter of the National Foundation for Infantile Paralysis, March 5, has appointed Dr. Edward Larkin to serve with the officers as a member of the Executive Committee. Drs. Larkin, Julius S. Neviasser, George C. Ruhland, Joseph S. Wall and Miss Gertrude H. Bowling were named to serve as the Medical Advisory Committee, with Dr. Larkin as Chairman.

Dr. John F. Owen, Superintendent of the State Hospital at Raleigh, N. C., has been appointed to head the new mental hygiene bureau in the Health Department. Dr. Owen will develop a program of mental hygiene in the District under the general supervision of Health Officer George C. Ruhland. Among the groups to be served by clinics to be established are preschool and school children, children involved with Juvenile Court and Detention Home, alcoholics and drug addicts, adults accused of anti-social behavior, and patients now at St. Elizabeths Hospital who need only psychiatric clinic supervision. An appropriation of \$24,340 will finance the project.

Dr. Owen has served as a physician in the U. S. Public Health Service and with state hospitals in Illinois and Massachusetts. He served as assistant physician at the Raleigh Hospital from 1936 to 1942, when he was named Superintendent.

Dr. Ernest Sheppard was recently appointed Professor of Ophthalmology at the George Washington University School of Medicine, succeeding the late Dr. William Thornwall Davis. The appointment was made by the Board of Trustees of the University on December 1, 1944.

The fifth anniversary of the opening of **Doctors Hospital** was celebrated March 7. At the brief ceremonies Dr. Charles Stanley White and Dr. Oscar B. Hunter, President and Secretary, respectively, of Columbia Medical Building Corporation, announced that a new Columbia Medical Building ten-story annex would be erected on 19th Street between I and K Streets, N.W., to provide office space for returning service physicians. The new



COLUMBIA MEDICAL BUILDING ANNEX

building will be constructed after the war at a cost of \$681,800.

Group Hospitalization, Inc. held its tenth annual meeting, March 23, at the Brookings Institution. The Board of Trustees authorized the extension of hospitalization benefits to groups of employed persons in Virginia and Maryland considered by the Census Bureau to be within the Washington Metropolitan Area, subject to approval by legal counsel and by the Maryland and Virginia hospital service plans. Action was also taken to broaden the mem-

bership by including groups of five persons instead of the previous minimum of ten.

GHI voted to establish reciprocal relations with other recognized prepayment hospitalization plans throughout the country.

All officers were reelected at the meeting, including Joseph H. Himes, President; George H. O'Connor, First Vice President; Charles H. Drayton, Second Vice President; Dr. Francis X. McGovern, Secretary; and Sidney F. Taliaferro, Treasurer. Three trustees were reelected for another term: General Frank T. Hines, Frank Jelleff and Mr. Taliaferro.

GHI now has 220,000 members. The Doctors Group of the Medical Society numbers 421 subscribers or a total participating membership of 1,275.

Brigadier General Hugh J. Morgan, M.C., U.S.A., Chief Consultant in Medicine to The Surgeon General of the Army, has been elected President-elect of the **American College of Physicians.** General Morgan was previously a member of the Board of Regents of the College.

Dr. Benjamin Rones appeared before the Section of Ophthalmology of the New York Academy of Medicine, February 19. He read a paper entitled, "Traumatic Ocular Injuries in Soldiers."

Mr. Theodore Wiprud was reelected for membership on the Board of Directors of the Council of Social Agencies for a three-year period at the Annual Meeting of the Council, April 9.

Dr. Joseph S. Wall was one of four lecturers who addressed the Christian Clinic for Parents sponsored by the Washington City Presbytery. These lectures concerned the fields of medicine, psychology, sociology and education as they relate to family life. On March 13 Dr. Wall discussed "Sane Health Principles for Parents and Children."

Upon the recommendation of the Society's Executive Board **Dr. Edgar McPeak** and **Dr. Alan F. Kreglow** were appointed by Mr. Harvey J. Cheston, Chairman, City Division, 1945 Red Cross War Fund Campaign, to serve as captains in the Red Cross drive for the Columbia Medical Building and the Washington Medical Building, respectively.

Dr. Samuel M. Dodek attended the annual meeting of the Alumni Association of the Jefferson Medical College in Philadelphia, February 15, 1945, and was elected Vice President for the District of Columbia for the fourth successive term. Dr. Dodek requests that all graduates of Jefferson Medical College who live in the District of Columbia send him any items of interest. He would like especially service records of graduates with the armed forces; they will become a part of the permanent record of World War II.

Dr. George C. Ruhland completed his tenth year as District Health Officer, March 1. A luncheon was given in his honor at the Statler Hotel by the bureau chiefs of the Health Department. The Health Department announced that since 1935, Washington's death rate had been reduced from 14.3 per 1,000 population to 9.9 in 1944, a drop of 30.7 per cent. The personnel of the Department now numbers 818 compared with 246 in 1935, while appropriations for the Department have risen from \$396,519 ten years ago to \$1,480,000 for 1945. The figures for 1945 do not include personnel of or expenditures for Gallinger Hospital and Glenn Dale Sanatorium. These institutions were not transferred to the Department until July, 1937.

Dr. Ruhland, a graduate of Marquette University, served as Director of Laboratories at Fort Sill, Okla., during the last war and attained the rank of Major. He served as Health Commissioner of Milwaukee from 1912 to 1924 and as Commissioner of Health and Director of the Syracuse (New York) Health Administration from 1924 to 1935.

Dr. I. Philips Frohman attended a course in cardiology given by Dr. Charles A. Poindexter at the New York Postgraduate School and Hospital, March 12-16.

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review. After the reviews have been published the books will be placed in the New Book Section in the Medical Society's Library. There they may be examined at leisure but cannot be removed from the building.

Clinical Roentgenology of the Digestive Tract, 2nd ed. MAURICE FELDMAN, M.D., Assistant Professor

of Gastroenterology, University of Maryland; Assistant in Gastroenterology, Mercy Hospital; Consulting Roentgenologist, Sinai Hospital. Price, \$7.00. Pp. 769, with illustrations. Baltimore: Williams & Wilkins, 1945.

Alcoholics Are Sick People. ROBERT V. SELIGER, M.D., Assistant Visiting Psychiatrist, Johns Hopkins Hospital, in collaboration with VICTORIA CRANFORD; edited by HAROLD S. GOODWIN, B.A. Price, \$2.00. Pp. 80. Baltimore: Williams & Wilkins, 1945.

My Second Life. THOMAS HALL SHASTID, A.M., M.D., LL.B., Sc.D., F.A.C.S., F.A.C.P. Price, \$10.00. Pp. 1174, with numerous illustrations. Ann Arbor, Mich.: George Wahr, 1944.

CORRESPONDENCE

WASHINGTON, D. C., March 8, 1945

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA
1718 M STREET, N.W.

WASHINGTON, D. C.

ATTENTION: MISS ECKBURG

DEAR MISS ECKBURG:

This is to report that we have received here at the Library of Congress the journals you offered to us for use in restocking foreign libraries after the war. We are very glad to have this material and wish to thank you for your generosity in making it available.

We hope that you will keep our project in mind if you have other material available later on.

Sincerely yours,

DOROTHY J. COMINS
Executive Assistant, Committee on Aid to Libraries in War Areas, American Library Association

EDWARD RICHARD GOOKIN, M.D.

1882-1945

Dr. Edward R. Gookin, ophthalmologist, died suddenly March 6, 1945, at his home, 1113 16th Street, N.W.

Dr. Gookin was born April 18, 1882, in Boston, Mass. He graduated in medicine from the University of Maryland in 1906. For the next ten years, 1907 to 1917, he practiced medicine in Massachusetts. During World War I he served with the

Army Medical Corps. Following the War he attended New York Postgraduate Medical School and the University of Vienna, Austria. He established a practice in the District of Columbia in 1925, and in subsequent years served on the faculties of both George Washington and Georgetown Universities Schools of Medicine.

Dr. Gookin became an Active Member of the Medical Society of the District of Columbia in 1926. He was a Fellow of the American Medical Association and a member of the American Ophthalmological Society. He also held membership in American Legion Post No. 1 and Disabled American Veterans Post No. 1, and was affiliated with St. John's Episcopal Church.

His special hobby was fire prevention. He had attended many of Washington's major fires and his office was lined with famous fire pictures. He was instrumental in organizing the Friendship Fire Association in 1940.

His wife, Mrs. Eleanor Jackson Gookin, survives him, together with two daughters, the Misses Carroll and Eleanor Gookin, and a son, Richard J. Gookin, all of Washington, and a sister, Mrs. Catherine Egan of Quincy, Mass.

ROBERT SAMUEL JACOBS, M.D.

1906-1944

Dr. Robert S. Jacobs, who resided at 1401 Fairmont Street, N.W., died July 11, 1944. Announcement of his death was only recently received at the Society's office.

Dr. Jacobs was born in Norfolk, Virginia, February 19, 1906. He received his A.B. degree from Johns Hopkins University in 1926 and his degree in medicine from the Medical College of Virginia, Richmond, in 1930. Following his graduation he engaged in successive internships and studied at postgraduate clinics. Upon the death of his father, who was a resident of the District of Columbia, Dr. Jacobs came to Washington to engage in the private practice of medicine.

He was elected to Active Membership in the Medical Society of the District of Columbia in 1935. He was also a Fellow of the American Medical Association.

Surviving are his mother, Mrs. Benjamin Jacobs, and a brother, Leonard W. Jacobs, both of Washington, and a sister, Mrs. Marcus Bassevitch, of Hartford, Conn.

Dissecting Aneurysm—Steiner

(Continued from page 159)

4. SAMSON, P. C.: *Ibid.*, 1931, 5, 117.
5. KELLOGG, F., AND HEALD, A. H.: *J. A. M. A.*, 1933, 100, 1157.
6. WOOD, F. C. (Philadelphia), PENDERGRASS, E. P., AND OSTRUM, H. W.: *Am. J. Roentgenol.*, 1932, 28, 437.
7. ROESLER, H., GIFFORD, U. G., AND BETTS, W.: *Am. Heart J.*, 1937, 13, 426.
8. McGEACHY, T. E., AND PAULLIN, J. E.: *J. A. M. A.*, 1937, 108, 1690.
9. OSGOOD, E. E., GOURLEY, M. F., AND BAKER, R. L.: *Ann. Int. Med.*, 1936, 9, 1398.
10. GLENDY, R. E., CASTLEMAN, B., AND WHITE, P. D.: *Am. Heart J.*, 1937, 13, 129.
11. WILSON, F. N.: *Ibid.*, 1944, 27, 82.
12. OSLER, W.: *Mod. Med.*, Phila., 1908, 4, 448.
13. REISINGER, J. A.: *Arch. Int. Med.*, 1940, 65, 1097.
14. DAVY, SIR H., AND GATES, MABEL: *Brit. M. J.*, 1922, 1, 471.
15. SWAINE: *Tr. Path. Soc. Lond.*, 1855-56, 7, 106.
16. HIRSCHBOECK, F. J., AND BOMAN, P. G.: *Minnesota Med.*, 1922, 5, 724.
17. BLACKFORD, L. M., AND SMITH, C.: *J. A. M. A.*, 1937, 109, 262.
18. HOLLAND, L. F., AND BAYLEY, R. H.: *Am. Heart J.*, 1940, 20, 223.
19. WALKER, C., AND WALKER, L.: *Brit. M. J.*, 1919, 2, 200.

In and Out of Focus—Observer

(Continued from page 173)

the discussion. Some of those present were getting weary and shifted about uneasily in their chairs. It was midnight before the meeting adjourned.

Your Observer was one of the last to leave. A physician who had been present at the meeting was waiting for him at the door. There was some discussion in front of the Society's building.

The doctor said the meeting was another example of time that might well have been profitably devoted to something else. Life had become too complicated and the pace too fast. It just wasn't worth the candle. Suddenly he smiled. He said he had something he would like your Observer to see.

Walking over to a street light, he pulled a pamphlet out of his pocket. Somewhat embarrassed, he said, "You'll never guess what this is. You know, I have been thinking about the future." Unfolding the pamphlet he pointed to the title on its cover. It read: "Circular No. 721—The Farming Situation, 1943-44, U. S. Department of Agriculture."

Absenteeism and Medical Certificates

(Continued from page 186)

the patient will have in his doctor if the latter unwittingly or not, falls in with such a procedure to circumvent common honesty.

The tendency of some workers is to indict fumes, gases, dust, etc., for real or alleged ill health. Actually, few unskilled workers know what if any occupational hazards exist in their working environment. Such a worker, in the role of a patient, may influence the family doctor to a most astounding and untenable diagnosis. It seems opportune to urge that physicians protect themselves in this respect by using confirmatory sources of information.

State and local industrial hygiene divisions can give the private physician information on the specific environmental health conditions in a particular plant on request, when there is any question concerning the possibility of illness being incurred on the job.

They can also assist industries in developing a standard form of certificate for physicians to use in making reports and can bring this subject to the attention of medical societies.

MEDICAL ANNALS

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PSYCHIATRY IN BRAZIL*

OSWALDO CAMARGO, M.D.

Psychiatric Inspector for the Public Health Department of Brazil

SOME distinguished American psychiatrists and friends of mine have asked me: In what ways is Brazilian psychiatry different from ours? How do they teach psychiatry in Rio de Janeiro? Do you have the electroshock, insulin and other modern treatments there?

I like those questions. We are living in a period of rapid development of relations among people having similar ideas. Hemispheric amity has brought us, among other things of undoubted value, a better understanding of each other. Some sociologists have declared that while science constitutes a solid unit everywhere, there ought to exist, nevertheless, a difference in its application and interpretation among peoples of different cultures, climates, and regions of the world.

I think they are right. Nevertheless, I do not detect any radical differences between Brazilian and American psychiatry. At the same time there are a few unique aspects that give our psychiatry a special color that should be seen and understood. To begin with, the classifica-

tion of mental diseases in my country is a little different from yours. Instead of the 24 types, as seen in the Condensed Classification of Mental Disorders approved by the American Psychiatric Association, we have adopted a list of only 14 types, 2 of which do not appear in the American classification. Those 2 types are paraphrenia and the chronic systematized hallucinatory delusional state. I will explain the reason for this shortly.

Let me tell you first how psychiatry developed in Brazil. Our oldest psychiatric hospital was established in 1841 in Rio de Janeiro, our capital, by Don Pedro II, at that time Emperor of Brazil. It had a capacity of 400 beds. When the monarchy was supplanted by the republic in 1889, the hospital had grown to 1,500 beds. In addition, several other mental hospitals had been built in different parts of the country. About that time a special chair of psychiatry in the Brazilian medical schools was created. The teaching of this specialty was, on the whole, based on French and German ideas. Our doctors who were interested in the subject perfected their knowledge through reading French and German books. Many young physicians, after graduating in Brazil, went to Europe to

* Presented before the Section on Neurology and Psychiatry of the Society, at a special program dedicated to Latin-American Neuropsychiatry, March 1, 1945.

learn psychiatry in the clinics of Munich, Berlin and Switzerland; others went to study with Toulouse, in Paris, and to visit the famous French hospitals. It was only a few years ago that the South American psychiatrists began to really become acquainted with the splendid progress of this branch of medical science in the United States.

I wish to answer here a question raised in the October issue of the *American Journal of Orthopsychiatry* by Dr. Jules Henry. In a review of a recent book by a group of Brazilian psychiatrists Dr Henry pointed out that most of their bibliographical citations referred to European authors, and very few referred to Americans. Dr. Henry attributed this situation in part to American medical isolationism. It may be interesting to point out some of the other reasons. For many years Brazil was under a very marked European cultural influence. It is a country of Latin origin, discovered and developed largely by Portugal. During a certain phase of the colonial period Portugal sent many French artists and scientists to Brazil, and they collaborated actively in our spiritual and intellectual development. Hence it was natural that our ties with French culture should be rather strong. Since ours was the only Portuguese-speaking country in the American Hemisphere, and having a population of over 40 million, Brazil became an excellent market for French books, especially since the great majority of our intellectual class read French easily.

Until about 20 or 25 years ago almost all the books in our medical schools were written in French and imported from France. The admiration that our great psychiatrists had for French and German psychiatry can be seen still today in the names given to the various sections and pavilions of our mental hospitals: Pinel, Esquirol, Calmeil, Morel, Seguin, Magnan, Bourneville, Kraepelin, Bleuler, Griesinger, etc. And when the Brazilian Psychiatric Society met more than 20 years ago to decide the classification to be adopted for mental disorders in Brazil,

"paraphrenia" had a special place in that classification as homage paid to Kraepelin. It is considered a nosological entity there, while in the United States and England it is included preferably either in the paranoid states or in paranoid schizophrenia. The most famous Brazilian psychiatrist, who was director of the Psychiatric Hospital in Rio for almost 30 years, married a German woman. I believe that such data will help to clarify the reason for our close ties with European authors.

Now let us turn to the matter of classification. The Brazilian Classification, with but 14 types of mental disorders, was submitted by our great psychiatrist, Professor Henrique Roxo from Rio de Janeiro, to the First Latin American Conference on Neurology, Psychiatry and Legal Medicine, in 1928, and it was accepted by many neighboring countries, with but very little modification. Besides Kraepelin's "paraphrenia" there appears in this classification a type that is exclusively Brazilian, created by Professor Roxo, "the chronic systematized hallucinatory delusional state," which he submitted to the 17th International Congress of Medicine, in London, in 1913. The author explained his point of view as follows: "There exists a chronic mental disease that manifests itself by hallucinations, delirium and systematic delusions of persecution; it develops gradually and does not interfere with other mental processes; the hallucinations are almost exclusively auditory and cenesthetic; the first manifestation is the hearing of confused noises, which increase gradually, resulting in delirium, which sometimes turns out to be the persecuted-persecutor delusion type." That is all.

Psychiatry is taught today at 13 medical schools in Brazil. The period of study in the medical schools is 6 years, and psychiatry is usually taught in the last year for 1 semester. I know that in several medical schools in the United States psychiatry is taught during all 4 years, which seems to me a very good idea. Our teaching program includes technical and

practical classes with an obligatory period on the wards in order to learn directly how to handle the mental patients. In spite of the short time (only 1 semester) the classes are given satisfactorily. From the point of view of doctrine there are 2 major psychiatric schools, that of Rio de Janeiro, of which Dr. Roxo, who has been teaching for more than 40 years, is the leader, and that of São Paulo, Brazil's second largest city, of which Dr. Pacheco e Silva is the leader. The first is characterized by its great interest in the problems of mental disease in its relation to the community. It attempts to extend its services from the hospital to the home, and it is fighting for the creation and development of psychiatric clinics everywhere. Professor Roxo is the present head of the Brazilian Mental Hygiene League. The "Paulist School" (from the name São Paulo) has available the huge Juquery center with nearly 8,000 mental patients. The Psychiatric Clinic which is being built now by the São Paulo University is a complete unit for research and teaching, with 150 beds, and will cost a little less than a million dollars, according to the July 1944 number of the *Journal of the American Psychiatric Association*.

The Director of the Federal Department of Public Health, Dr. Barros Barreto, introduced an obligatory course of psychiatry and mental hygiene at the official school of hygiene and public health. Besides that, he created, a few years ago, an intensive postgraduate course in psychiatry, which runs for 4 months every year, under the auspices of the National Service for Mental Diseases, of which Dr. Aduauto Botelho is the director, for the main purpose of preparing adequately a large group of physicians from the states to take the leading posts in the mental hospitals scattered all over the country. This course has been very successful, and the number of physicians interested in that field has increased considerably. In conjunction with the National Service for Mental Diseases there is operated the oldest school for psychiatric nurses in South America, the Alfredo Pinto School, created in

1890, with a 2 years' course and 1 additional year for social workers. The total number of nurses (both sexes) graduated by that school to date is more than five hundred. It is an official establishment maintained by the federal government.

What are the most common types of mental disease in Brazil? Schizophrenia is first, with 25 to 30 per cent of all first admissions; second, the manic-depressive psychoses, about 20 per cent; following these, general paresis and other luetic mental disorders, 12 to 15 per cent; and alcoholic psychoses, 10 per cent. There are 2 other types which in other countries perhaps are not so common: one is "psychosis due to malaria," that endemic tropical disease which we are fighting vigorously in the Amazon River Valley, the rich land of the native rubber trees; the other is the "episodical spiritistic delirium," a form of mental disorder which appears in some people who practice the black magic rituals (we call them "candomblés") or who are attached to some sort of low-grade spiritistic religion (the evocation and visualization of the ghost of a dead person). Naturally all these patients are people with predisposition to mental trouble. In a paper about "Spiritism and Schizophrenic Reactions" presented at the Southern Psychiatric Association's meeting, Dr. Katzenelbogen discussed a case observed in St. Elizabeths Hospital in 1940, and pointed out that the number of such patients in mental institutions in the United States is rather rare.

In my country it is different; between 1925 and 1934 these cases constituted about 3 per cent of all first admissions in Rio de Janeiro.

Drug addiction is not so widespread in my country, fortunately. We had a fair number of cocaine, opium and morphine addicts soon after World War I. The energetic campaign maintained by the health authorities in collaboration with the police and the newest laws of the control of the importation and trade in narcotics, rather severe laws in my country, brought about the almost complete disap-

pearance of cocaine and opium addicts. We have some cases of morphine or heroin addiction, but the number of them is not important. There is in Brazil a native plant whose leaves are used as cigars by addicts; it is called "maconha," very similar to "marihuana," with the same clinical features. The number of cases is quite low.

And about hospitalization? We have 92 mental hospitals, covering 20 states and the Federal District of Rio de Janeiro. Eight of them are federal hospitals, 26 are state hospitals, and the remaining 58 belong to charitable institutions or to private corporations. The total number of beds for mental patients is 26,000. The hospitalized patients are concentrated around the big centers of population. For instance, in Rio de Janeiro we have 7 federal hospitals and 14 private sanitariums, all together housing nearly 6,000 mental patients; in the Juquery, São Paulo State, there are about 8,000; the state of Rio Grande do Sul, in the extreme south, has about 2,500; the state of Minas Gerais, in the middle of the country, has 3,000. On the other hand, we have a large state, Matto Grosso, with only a very small mental institution, whose capacity is 25 beds. Our big problem is transportation. The lack of good roads in some central areas prevents the shipment of materials and equipment for establishing new hospitals. It takes 2 days by plane to reach 1 hospital in Amazonas from our office in Rio de Janeiro; by ship, the only other available means of transportation, it would take a month.

One of the faults of our mental hospital system is the lack of special hospitals for the feeble-minded, for epileptics and for alcoholics, for they are received indiscriminately in every mental hospital. On the other hand, we give greatest consideration to the criminally insane. We have 5 special psychiatric hospitals for them (we call them "manicomio judiciário"), 1 in each of the following states: Rio Grande do Sul, São Paulo, Minas Gerais, Paraíba and Rio de Janeiro city.

The federal government is planning to build now a new hospital for the criminally insane in Rio, where we have a very fine group of psychiatrists interested in this field. The construction of new units for mental patients is being accelerated by the present government of Brazil, which has spent more than \$3,000,000 in the last 6 years in the Federal District alone. Our government's interest in improving the service to mental patients has reached such a point that our Ministry of Education and Health has given the highest priority (A-1) to the construction of such units. That is to say, any other buildings for schools, general hospitals, etc., can be constructed only when the construction of mental hospitals has been finished.

Let me tell you a few words about treatment. All the modern therapeutic methods in psychiatry have been applied in Brazil. Metrazol and insulin are used there with the same technic as in the United States. Metrazol, which is known in Brazil by the name of Cardiazol, was our favorite agent in convulsive therapy until 1943. Shortly before coming to the United States, von Meduna was in Brazil by official invitation, having given several lectures there about his original treatment of schizophrenia. The insulin coma is widely used too, according to the classical Sakel method. And we have started to use the modified insulin treatment according to Thomas Rennie's presentation. Electroshock therapy is being used widely now in Brazil, not only in state and federal hospitals, but also in private sanitarium. Besides the machines imported from the United States (the federal hospitals bought 12 in 1943), there are 2 or 3 types made in Brazil. Narcoanalysis by sodium pentothal is being used in São Paulo, in Professor Paulino Longo's psychiatric service. Psychoanalysis has some skillful practitioners in Rio de Janeiro and São Paulo, but unfortunately its application has been exclusively in private practice.

The originality of psychiatric treatment in Brazil consists in the use of fluid extracts of

medicinal plants, some of them growing exclusively in our climate, others found everywhere. Professor Roxo likes this kind of treatment very much, and he has published several interesting papers on the subject. One of them was presented to the American Scientific Congress in Washington, D.C. in 1940. Professor Roxo is also enthusiastic about psychosomatic medicine, which he teaches and practices in the Psychiatric Institute. Hydrotherapy, continuous bath, cold packs, etc., are used in our mental hospital routine.

About malariotherapy in general paresis, we Brazilians presume to have had precedence in the introduction of that treatment in South America. Almost immediately after the publication of the original method of Wagner Von Jauregg in Europe, 2 Brazilian doctors (Waldemiro Pires and Gilberto Moura Costa) started to use it in Rio de Janeiro, where they created a special center for treatment of syphilis of the nervous system. That center is now the Institute of Neurosyphilis, under the federal government, with 160 beds. A curious fact is that the Institute has had the same strain of *plasmodium vivax* (tertian benign) since 1926, which has passed from one patient to another with undiminished success. Several important studies have been done in the Institute. A few years ago its director, Mathias Costa, published an interesting observation on the negative Wassermann response of the spinal fluid in several cases of neurolues, when taken by suboccipital puncture, but showing positive response if taken by lumbar puncture. In the Juquery Psychiatric Center, one entire unit with 300 beds is working exclusively on neurosyphilitic cases.

Researches in mental hospitals are being done mainly in Rio and São Paulo. The places in São Paulo are the Juquery Central Hospital and the Psychiatric Clinic of the School of Medicine. In Rio they are being conducted at the Psychiatric Institute of the Brazilian University and the National Service for Mental Diseases,

which has just built and is equipping a beautiful 8-story concrete building for research in mental diseases. Special studies on pellagra are being conducted in the Colonia Juliano Moreira, in Rio de Janeiro. An interesting study on cutaneous reactions accompanied by intestinal disturbances and psychomotor agitation in mental patients exposed to prolonged action of the rays of the sun in the hospital yards on hot summer days was made by Dr. Edgard Pinto Cezar, director of the Juquery Hospital. The high incidence of tuberculosis in mental cases, which has been observed everywhere, has received the special attention of the National Service of Mental Diseases. This Service decided to undertake chest examinations of all patients in the federal hospitals. This examination is made by roentgen-photography, an original Brazilian method created in 1936 by Dr. Manoel de Abreu, Professor of Radiology at the Faculty of Medical Sciences, which is widely used in almost all the South American countries. This practical and inexpensive method which we use in the periodic routine examinations was presented by its author to the 8th American Scientific Congress in 1940, and now is officially used in the United States by special recommendation of the Surgeon General.

One field in which we have a fair development is that of mental hygiene. Dr. Ramires Moreno, the well known Mexican psychiatrist, has said that Brazil is the pioneer in mental hygiene in South America. The fact of the matter is that since 1923 we have had a Brazilian League for Mental Hygiene in continuous operation. Founded by Gustavo Riedel and Ernani Lopes, our league since then has been organizing courses and educational lectures, establishing mental hygiene clinics all over the country. The results of that work have been so convincing that the government decided to grant financial support to it. At present we have in Rio 3 mental hygiene dispensaries, all of them giving clinical consultation and medicines entirely free. The Public Health Department, through the National Service for Mental Diseases, has created 9 dis-

pensaries scattered through several states, and is planning to have 5 more. The State Department of Mental Diseases in São Paulo has a very fine dispensary in the center of the city, staffed with 4 part-time psychiatrists and 2 psychiatric nurses; it has also an association for the protection and help of mental patients, organized by leading São Paulo women.

The Brazilian League for Mental Hygiene generally holds each year, in October, an anti-alcoholic week, with an intense campaign over the radio, in the press, through lectures in the high schools and colleges, all over the country. The Department of Education of the city of Rio de Janeiro holds an interesting contest on this occasion in the primary schools, distributing prizes to the children who produce the best compositions on the subject of alcoholism.

In Brazil there are 2 large mental hygiene clinics for school children, 1 in São Paulo, under the direction of Dr. Durval Marcondes, staffed with 3 child psychiatrists, 2 psychologists and several psychiatric social workers; another in Rio de Janeiro, under the direction of Dr. Pernanbuco Filho, also very well staffed and equipped, having a modern laboratory of experimental psychology organized by Professor André Ombredane from Paris, who is now teaching in the Brazilian University. Rio has also a modern Neuropsychiatric Hospital for Children, opened by the federal government 3 years ago with 200 beds. All the equipment for its department of psychology was imported from the United States, and the chief of that department is an able European psychologist, a former pupil of Claparède in Switzerland. The hospital has a school for feeble-minded and an outpatient department. The Juquery Hospital, in São Paulo, has an excellent section for abnormal children, with nearly a hundred beds, called Escola Pacheco e Silva. With respect to experimental psychology I ought to mention also that the Gustavo Riedel Colony in Engenho de Dentro has a famous laboratory which was installed 20 years ago by Dr. Ernani Lopes with an

abundance of apparatus unequalled in South America; that laboratory has been a veritable training school for large numbers of Brazilian psychologists.

What more can I tell you about psychiatry in Brazil? The cultural interchange among all our psychiatrists is carried on theoretically through the Brazilian Society of Psychiatry, Neurology and Legal Medicine, with offices in Rio de Janeiro. I said "theoretically" because in reality it is not. Due to the lack of convenient transportation in a large country like Brazil, the specialists in the various regions prefer to meet in their own local associations. Almost all the medical societies in the states have psychiatric sections, which meet periodically to present and discuss papers. A few years ago some of the states of the Northeast decided to found a Psychiatric Association of the Northeast, with offices in Recife, and they have held several meetings. Works of research and clinical findings in the mental hospitals are published in several psychiatric journals, such as *Neurobiologia*, *Neuronio*, *Arquivos de Neuropsiquiatria*, *Arquivos Brasileiros de Higiene Mental*, besides various important annals, some of them of more than 800 pages, such as, for example, that of the National Service for Mental Diseases, and the Juquery Hospital.

The standards that regulate the functioning of the psychiatric hospitals and private sanatoria all over the country are the same. Through a federal law on the subject of assistance to the mentally ill, no one may open a mental hospital without a license from the health authorities, and without first presenting blueprints and details of the building and proof that the medical director is a registered psychiatrist, etc. All the institutions for the mentally ill are subject to federal inspection from the technical, professional, material, and general service points of view. Since the law is fairly recent, there are still a number of old establishments in existence that cannot fulfill the requirements for the

(Continued on page 236)

PLANS FOR FEDERAL EMPLOYEES' HEALTH SERVICE*

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 IN JANUARY 1942 the Council of Personnel Administration of the Civil Service Commission presented to the Federal Security Administration a request for help in drawing up plans for medical divisions in the government agencies in Washington, D. C. This request, with an accompanying preliminary outline of needs and recommendations for a program, was then submitted to Dr. Selby, Chairman of the Subcommittee on Industrial Health and Medicine of the Health and Medical Committee of the Office of Defense Health and Welfare Services. This subcommittee has approved these recommendations and transmitted them to the Public Health Service with the request that further studies be made as a basis for working recommendations.

On June 2, 1942 the Surgeon General of the Public Health Service submitted a report entitled "A Health Program for Federal Employees." This report was accepted by the Council, and steps advocating a health program have been taken to accomplish the establishment of a health program in governmental departments and agencies.

The Federal Government is the largest employer in the nation. Its civilian workers, especially those in Washington, D. C., are directly concerned with the war. Estimates have shown that the average annual time lost due to sickness and accidents among the 250,000 Federal employees in Washington is 7.8 days per employee, or approximately 2,000,000 days annually. In one large government department in 1942 illness caused an average loss of 10.2 days per employee. The National Association of Manufacturers reports that the installation of

medical and health programs was accompanied by a 29.7 per cent reduction in absences due to sickness (other than occupational disease). If this one federal department could improve its illness record by 3 days per employee, more than 246,000 man-days would be saved, the equivalent of 820 employees' full-time services for one year.

The demands of the war upon the manpower supply has resulted in the increased employment of women, older workers, and physically handicapped individuals. This was inevitable as our Armed Forces and war industries expanded. The return of disabled veterans to civilian status and to federal jobs presents problems in placement and post-placement which will demand that governmental agencies have adequate health services with trained and competent medical personnel to assist the operating officials to meet this problem adequately.

Medical officers of the U. S. Public Health Service and physicians from the Medical Division of the Civil Service Commission jointly worked out the plans for a Federal Employees' Health Service. Dr. Verne K. Harvey, Medical Director, U. S. Civil Service Commission, has presented this plan before the Industrial Hygiene Section of the American Public Health Association at the 73rd Annual Meeting in New York, N. Y., on October 3, 1944. Some of the material in this paper is identical with that used by Dr. Harvey.

THE HEALTH PROGRAM FOR FEDERAL AGENCIES OR DEPARTMENTS

A Health Unit in a Federal agency or department has for its purpose the developing of a health program to promote better health of personnel, conserve human energy, promote effi-

* Read before the Society, March 28, 1945.

ciency, reduce absenteeism, and increase production. This necessitates close liaison between the Health Unit and the Personnel, Safety, and Engineering Divisions.

The object is to furnish employees the best possible health protection consistent with:

- a. The purpose of the agency or department
- b. The Federal Government's responsibility as fixed by the Compensation Act of 1916 as amended
- c. The employee's natural allegiance to his family physician
- d. The limits placed upon industrial medicine by the code of ethics of the medical profession.

The physician is the health officer of the organization. His responsibilities may be divided into three categories:

- I. Preventive Services
- II. Advisory and Diagnostic Services
- III. Treatment

Such a program can be accomplished through the following:

- I. Preventive Services
 - A. Physical Examinations
 1. Preplacement examinations
 - (a) Original
 - (b) Reassignment
 2. Periodic
 3. Examination after illness
 4. Fitness for continuing assignment, separation, change of duty, or retirement
 - B. Promotion of Adequate Environmental Hygiene
 1. Light, ventilation, water supply, distribution of food and garbage disposal, insect and rodent control
 2. Fatigue Prevention Program—noise reduction, adequate rest periods, vacations, refreshments, and posture aids
 3. Elimination of specific occupational hazards, such as solvents, gases, dusts, and others

C. Control of Communicable Diseases

1. Tuberculosis
2. Venereal Diseases
3. Others

D. Mental Hygiene

1. Evaluation of emotional factors by physicians

E. Health Education in which various forms of media are utilized for presentation on an individual, and personalized basis as well as on a group basis

1. Nutrition
2. Health hazards (seasonal and general)
3. Physical fitness
4. Communicable diseases
5. First aid

F. Health Records

1. Regarded as confidential and retained in the Health Unit. Interpretation to be provided by the physician

II. Diagnostic and Advisory Services

- A. Evaluation of employee's symptoms and referral to private physicians
- B. Interpretation of conditions revealed by preplacement and other physical examinations to the employee to encourage him to maintain good health, also to the operating official, in understandable terms for purposes of more adequate individual job placement and job adjustment

III. Treatment

- A. Prompt and efficient handling of accidental illnesses occurring in line of duty by providing treatment on the spot and referral to proper facilities for complete and adequate care
- B. Treatment on the job of minor noncompensable injuries and disease, with the object of keeping employees at work
- C. Rendering of emergency care for serious non-service connected injury or disease and referral to a private physician or hospital
- D. Special treatments to be given only on

the written request of the employee's private physician

It is essential for such a health program to function efficiently that the administrative placement in the organization should be as high as feasible to enable the physician in charge to have access to top management and to assure close coöperation and coördination with personnel, safety and other operational divisions of the agency.

It is imperative that an adequate staff of personnel, competent and trained in the basic principles of industrial and preventive medicine, be acquired in order that the effectiveness of the health program be maintained on an efficient level. It is estimated that there should be at least 1 physician per 4,000 to 6,000 employees, the exact ratio depending upon such factors as distribution of employees, shifts worked, extent of industrial hazards, employee turnover, number of physical examinations, and patient case load. The number of nurses required is to be based on the treatment-interview load per nurse per day, which should not exceed 30. Approximately 1 nurse per 400 to 600 employees is a reasonable estimate.

Numbers of stenographers, clerical and/or medical record personnel depend upon the case load, number of rooms, distribution of employees and other factors. This group of personnel should be adequate to avoid the necessity of physicians and nurses performing routine clerical and non-medical duties.

Adequate space, equipment and supplies to support a health program are important.

It is important to point out that the establishment of a health program in governmental agencies would not displace the services of the government employees' private physicians. In fact, one of the purposes of such a program would be to refer the employee to the private physician ethically. Preventive medicine is the epitome of all medical practice. The health program would be, primarily, a broad preventive medical program. Medical care and treatment for individu-

als in need of this type of care should properly be obtained from the private physician of their own selection.

In summary, it is believed that a Federal Employees' Health Service

1. Is Preventive Medicine
2. Has been in effect in private industry
3. Is needed in government.
4. Is recommended by government to private industry
5. Should be adopted by government.

An Employees' Health Service would result in methods to:

1. Economize time
2. Economize effort
3. Increase efficiency of employee and department
4. Increase production of work
5. Increase employee morale, as it enhances personal security from health aspect
6. Facilitate and improve job placement, job adjustment and personality adjustment
7. Aid in adjustment of disabled war veterans and also non-disabled war veterans to a more tranquil mode of life in postwar period
8. Facilitate utilization of disabled individuals to mutual advantage of employee and government
9. Assist in development of good health habits
10. Assist in development of good interpersonal relationships between employee and employer and employee and administrator
11. Add "humaneness" by promoting a feeling of protection by government for its employees against health and accident hazards
12. Afford equal privileges for government employees as are afforded by private industry
13. Foster good relationship of employee and government with the private physician who strives at preventing disease, the absolute goal of modern medicine

14. Reduce early disability retirement
15. Reduce compensation costs
16. Protect taxpayers from support of individuals basically unfit for employment by virtue of nonremedial physical or mental employment hazards
17. Protect taxpayers from expense of paying compensation to employees acquiring illness or injury as a result of lack of professional evaluation of the health and subsequent proper utilization and assignment in jobs of fellow employees with physical and mental employment hazards
18. Facilitate an evaluation of the individual's illness or accident relative to work environment and foster methods to prevent future illness or accidents
19. Control communicable disease and therefore be of value to individual, community and the nation.

Present facilities are limited in number. In Washington there are approximately 125 Emergency Rooms in which are employed 257 nurses, 19 full- and part-time physicians. Of these, 38 Emergency Rooms are professionally supervised by the U. S. Public Health Service, and 9 medical officers are assigned for duty in these units. In addition the central consultative Employees'

Health Service is staffed by 1 medical director, 2 psychiatrists, 1 medical tuberculosis control officer, 2 psychiatric social workers, 3 public health nursing consultants, 1 nutrition consultant and 1 health educationist.

Approximately \$500,000 is expended annually for the operation of the 125 Emergency Rooms and Employees' Health Services in Washington. Approximately 250,000 federal employees gain from this service. However, the type and scope of service now rendered varies from that accorded to employees by medical officers with specialized training in industrial medicine and allied subjects, physicians without specialized training, nurses with specialized training in public health nursing, and nurses without any specialized training. Some departments employ matrons to assist nurses and furnish the necessary clerical assistance.

The present Emergency Rooms represent strictly first-aid stations, while the relatively few Employees' Health Units attempt to operate—limited, however, by lack of funds and dearth of adequate personnel—an over-all program of preventive medicine and health education.

The establishment of a Federal Employees' Health Service should prove to be good economy of human resources and should promote national health.

VENEREAL DISEASE PROPHYLAXIS*

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Washington

THE prevention of venereal disease is three-fold: (1) avoidance of infectious contact, (2) the use of true prophylactic measures, and (3) adequate treatment of infected patients until cured.

The elimination of venery would necessarily prevent venereal disease. However, this is an ancient custom that has been going on for generations and with our recent effective methods of treatment will probably outlive the diseases for many more generations to come. Certain legislation has been put through Congress from time to time to aid with the problem of infectious contacts, namely, the Venereal Disease Control Act of 1938, and the Federal May Act passed in 1941. It is rather obvious, however, that the venereal germs cannot be legislated out of the country; in fact, some of these "bugs" have a "home near the Capitol Dome." Many organizations with admirable intent find the suppression of sex a difficult problem. Prostitution may be reduced to a minimum by law, but it has now been found to be a negligible source of infection. The local regulation requiring food handlers and beauty parlor operators to stop work is no solution. Since the contact problem still remains unsolved, great reliance must be placed upon true prophylaxis.

The safest method of prevention has been found by authoritative sources to be the mechanical method. This consists of 2 phases: first, the condom of standard type; second, thorough washing of the genitals and adjacent parts with soap and water as soon as possible (the sooner the better, but within 1 hour at most) after removal of the condom. The chemical prophylaxis is acknowledgedly second best, con-

sisting of thoroughly washing with soap and water as already described, injection of 6 c.c. of 2 per cent strong silver protein solution after urination and held for 5 minutes, rubbing the genitals and adjacent parts with 33 per cent ointment of mild mercurous chloride (calomel ointment). This method has not been found practical in the military services where simplicity of instruction and execution is necessary. There remained to be found a "one-shot" protective tube against gonorrhea, syphilis and chancroid. Such a product was developed in both the Army and Navy with slight variation. The ingredients were sulfathiazole powder, mild mercurous chloride, anhydrous wool fat, and white petrolatum. Instructions for use were to urinate; wash with soap and water; dry; inject 1 gram of the ointment into the urethra, and close the meatus by compressing with the finger-tips; massage for 3 minutes; avoid urination as long as possible; apply ointment to other parts, and massage for 5 minutes. Out of 1,000 cases, 98 per cent had contacted prostitutes. Only 2 cases of gonorrhea occurred, and these were in persons who failed to report within 2 hours after exposure, the maximal time considered safe for successful prophylaxis. Prophylactic kits equipped with the above are available to military personnel where a fixed prophylactic station is not convenient. Under certain conditions where the kit is not available the men are given $1\frac{1}{2}$ grams of sulfathiazole by mouth immediately upon reporting in the morning after exposure. This dose is repeated at noon and seems to protect somewhat without the benefit of local injection. Where no medical officer is in charge 1 gram is advised instead of the larger dose. Facilities for blood levels are rarely accessible. The ordinary commercial chemicals for local injections available to

* Read before the Society, February 28, 1945.

civilians are not effective even if they are properly administered. I have seen as much venereal disease in those who have used these medications as in those who had been exposed and used nothing. The patient has a feeling of false security which is dangerous. Availability of the proper chemicals with instructions for civilian use should be considered immediately. The role of penicillin in prevention is yet to be determined, but has possibilities.

Congenital syphilis is preventable, and 80 per cent of our population (representing 30 some states) are protected to some extent by premarital and prenatal examinations. Early detection is enhanced by quantitative blood serologic tests. Penicillin may replace arsenicals in this field. Newer methods may supplant the old in prevention of ophthalmia neonatorum.

Here in the District of Columbia there are approximately 15 prophylactic stations, and although used by the military personnel, civilians are conspicuous by their absence. Fear of publicity may be a factor.

Probably the best prevention we have at our disposal is the actual cure of infected cases. Since man is the vector in the transmission of these diseases, we cannot remove him, but he can be cured by modern methods of treatment. These methods at present are in a state of flux. Some are being carried out by diligent rapid treatment centers, which now number about 70 throughout the country. Very important data are being collected. At present the trend of treatment for gonorrhea seems to be drifting away from the sulfonamides and toward penicillin. The two main reasons seem to be that the "sulfa" drug has produced resistance cases and asymptomatic carriers. What was at first considered a 90 per cent cure is now reduced to only

60 per cent. In this connection later reports are that "sulfa" is being discarded in some of the war theatres. Among many different methods penicillin is now used in 20,000 units of the sodium salt intramuscularly every 3 hours until 6 doses are given. The "cures" reach as high as 96 per cent. In the local rapid treatment center they are using 2 injections of 100,000 units (calcium salt) which is dissolved in beeswax and peanut oil. The blood level is maintained for 3 days by this procedure. The masking effect of the development of syphilis with prolongation of the incubation period must be countered by careful follow-up with periodic tests in blood serology. Syphilis is apparently coming to a compromised combined plan of treatment. It will probably rest somewhere between the highly publicized "1-day cure" and the old 2-year treatment. It has been found that by combining the antiluetic agents there is a synergistic effect whereby the dosage of each may be reduced. This new plan involves about 8 days during which time the patient receives 600,000 units of penicillin, 48 mg. of mapharsen and 0.6 gram of bismuth. This is a great reduction in the amount of penicillin over the original $1\frac{1}{2}$ million units required as a minimum and of mapharsen from the 1,200 mg. originally used; bismuth is relegated to only 3 injections.

Contrary to implications of the press a long period of careful meticulous laboratory tests determines the cure. The adoption of accurate criteria is a chronologic necessity. This fact refutes all premature lay publications as to short miraculous cures which without scientific basis is gross injustice to the medical profession. We cannot underestimate the time element required to definitely establish the fact that the patient is no longer a menace to himself or to others.

PENICILLIN THERAPY IN AMBULATORY GONORRHEA PATIENTS

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IN APRIL 1944 we were privileged to participate in a study of the local reactions from the intramuscular injections of several brands of penicillin.* This investigation could have been done on normal individuals, but, since penicillin at that time was limited to the use of the armed forces, this practice would have been wasteful. This report then covers the medicinal results of penicillin therapy in 87 ambulatory patients with gonorrhea.

Arbitrarily, 25,000 units of penicillin dissolved in 5 c.c. of a sterile isotonic solution of sodium chloride was chosen for the initial dosage and repeated every 3 hours up to a total of from 75,000 to 100,000 units of penicillin. Sites of injection were the large muscles of the buttock and upper arm.

Of the 87 patients, 60 were sulfa-resistant. Patients were white and colored, male and female, aged from 12 to 65, presenting all stages of gonorrhea.

Under this treatment there were 85 cures and 2 failures. Both failures were on females with clinical complications. These 2 patients were subsequently hospitalized and cured with an additional 150,000 units of the drug.

To illustrate the effectiveness of penicillin in ambulatory patients with gonorrhea the following case reports are offered.

A white army officer, aged 22, who had been exposed 3 weeks previously in Florida came to Washington to be

married and consulted the family physician, who referred him to us. He had received 72 sulfathiazole tablets with no beneficial effect. Examination revealed a profuse urethral discharge containing gonococci. Two days after receiving 100,000 units of penicillin all clinical signs had disappeared with the exception of a thin serous urethral discharge. Three successive cultures of prostatic and urethral secretions were reported negative. He is now happily married and serving in the front lines in Europe.

An unmarried white male, aged 24, who had been exposed 6 weeks previously had taken 4 courses of sulfathiazole, prescribed elsewhere, without benefit. Examination revealed a profuse urethral discharge, balanitis, bilateral epididymitis, and acute prostatitis. The patient experienced considerable pain on walking. Two days after receiving 100,000 units of penicillin all clinical signs had subsided and the urethral discharge was becoming thinner. Three successive cultures of the prostatic fluid were reported negative for gonococci. Ten days later all signs of the disease and its complications had disappeared.

Since the inception of this study many reports have appeared in the literature showing advances in treatment with penicillin, refinement of technic, proper and minimum dosage, and time interval between injections. Because 70 per cent of injected penicillin is excreted in the urine within 1 hour after injection, it would appear logical to shorten the interval between injections and in this way to maintain a constantly high blood level of penicillin. On the basis of this knowledge we are now employing 50,000 units of penicillin dissolved in 2 c.c. of sterile distilled water every hour for 4 injections for a total of

* The penicillin was furnished by the U. S. Food and Drug Administration, Federal Security Agency.

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STERNAL TRANSFUSIONS IN INFANTS

Report of a Fatal Case

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THE various routes of blood transfusion used today should be considered safe procedures, especially when given by one competent in such technic. However, none of these is to be considered without some degree of seriousness, since even in the most experienced hands accidents can and do occur.

In newborn infants such therapy becomes even more serious because of the added difficulty due to the size of the vessels and parts.

It must be remembered that the sternum of the newborn infant is not completely developed and that the marrow cavity is a very insignificant space when compared with that of an adult. Roughly it can be compared to an elongated cone whose base is in the manubrium and the apex extending to the level of about the third or fourth rib. It is centrally located and has its largest diameter at the base, which is very often less than 0.5 cm. in diameter. At the level of the second rib, where most transfusions are given, the diameter is less than 5 mm. Again it should be remembered that the thickness of the sternum in the region where the marrow cavity has developed is not much greater than the diameter of the cavity itself.

The following case demonstrates the seriousness of this procedure.

REPORT OF CASE

Infant R., a normal white female, was born on January 18, 1945 at 11 p.m. The next day at 7:30 a.m., it was first noticed to be markedly jaundiced. The following day it became very listless and apathetic. At 8:30 p.m. Hykinone and 60 c.c. of saline solution were given subcutaneously. On January 21 at 8 a.m. the infant

was found crying. The respirations were rapid, and the jaundice was more marked. At 1 p.m. hemorrhage from the nose and mouth was noted. At 2 p.m. a blood transfusion was attempted into the jugular veins, the anterior fontanelle and sternum. Death occurred at 4:29 p.m.

The blood picture taken on January 19 showed hemoglobin 10 grams or 66 per cent, red blood cells 2,730,000, white blood cells 33,700, with 12 per cent band forms, 54 per cent segmented leukocytes, 34 per cent lymphocytes, and 182 nucleated red blood cells per 100 white cells. The mother was found to be Rh negative and the infant Rh positive.

At autopsy recently made puncture wounds were found in the region of the anterior fontanelle, both jugulars and at the angle of Lewis of the sternum. When the breast plate was removed, the puncture wound seen externally was found to pass obliquely upward and into the anterior, superior mediastinum, just above the heart, where about 10 c.c. of clotted blood was found lying on the thymus and apparently compressing the vessels at the base of the neck. The passage of the needle through the sternum completely missed the marrow cavity, passing just lateral to it.

The remainder of the findings were compatible with those seen in similar cases of erythroblastosis, marked generalized jaundice, enlarged spleen and liver with congestion, edema of the lungs, congestion of the kidneys, and dilatation of the right side of the heart.

DISCUSSION

The seriousness of sternal marrow transfusions cannot be underestimated. In fact, I believe that any transfusion should be considered a major procedure and that the task should not be delegated to inexperienced hands or to one who is not cognizant of the dangers involved. Obviously, sternal marrow transfusions in infants presuppose an embryologic and anatomic knowl-

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President's Page

ON MAINTAINING HIGH STANDARDS

Those who heard Major General Ireland speak at the program given in his honor by the Medical Society on April 18 will recall his concern over the future of medical education. He said that one of the challenging tasks confronting the medical profession was to restore the high standards of medical training which existed previous to the war. Directing attention to the brief internships and residencies of those who have entered the armed forces, he said upon their return they should be encouraged to complete their education.

His emphasis upon these important matters was not lost to the thinking physicians in his audience. They are only too well aware of the fact that there has been an unavoidable lowering of the quality of medical education because of the accelerated training program. This must somehow be remedied in the postwar years. During the emergency quantity has been of the greatest importance. This should be reversed when peace comes because neither the people nor the medical profession should tolerate any but the best trained physicians.

Which brings up the point that there are still too many physicians who do not keep abreast of scientific progress. Some of them are practicing as they did 25 or 30 years ago. What should be done about these practitioners I do not know. But somehow they should be required to inform themselves and to provide their patients with the best medical care of which they are capable.

Finally, a word about the invasion of commercialism in medicine. Medicine is not a business, it is a high calling. Any physician who forgets this discredits not only himself but the profession as a whole. Those in our ranks who are concerned more with their incomes than with the service they render should be forcefully reminded that their actions are jeopardizing conscientious fellow practitioners to whom the patient is always first.

Wm. M. Ballinger

ACTING PRESIDENT

Washington Physicians of Yesterday



SAMUEL CLAGETT BUSEY, M.D., LL.D.

No name looms larger in Washington's medical history than that of Dr. Samuel Clagett Busey. Son of John and Rachel Clagett Busey, he was born July 23, 1828 on a farm in Montgomery County, Maryland, one and a half miles east of Cabin John Bridge.

He received his early schooling at Rockville Academy and began the study of medicine with Dr. Hezekiah Magruder. According to a biographer, his facilities for study were "a Cullen's Treatise on Materia Medica, 37 years old, several rusty scalpels and a tooth forceps." He completed his medical training as a private student of Dr. George B. Wood of Philadelphia, Pennsylvania. Shortly thereafter he established a practice in Washington.

In 1853 he became Professor Materia Medica at Georgetown University School of Medicine. Stricken with a serious illness in 1858, he did not recover sufficiently to begin practice again until 1868. The years that followed were the most productive of his life. He was President of The Medical Society of the District of Columbia in 1877 and during the years 1894 to 1899.

Very active in civic affairs, he was responsible for many progressive health measures in the District of Columbia. He retired in 1895 to devote himself to literary work, and died February 12, 1901 at the age of 73 years.

Editorials

"I'VE SEEN BUCHENWALD"

Thomas R. Henry, War Correspondent for the Evening Star (Washington, D. C.), is highly regarded by physicians in the Nation's Capital not only as a reporter but as a man. For a number of years he was a top-flight science writer. Few laymen know their way about in medicine as well as he does. And only a handful have the sound technical knowledge he has acquired.

Early in the war he was assigned overseas and for the time being at least he has forsaken scientific writing. His dispatches from the various European fronts are widely read. They are invariably informative and often dramatic. None has shown greater depth of feeling than the one which follows. "Tom" addressed it to his friends in our Society. It was a front-page story in the Evening Star for April 24.

Medical men everywhere will deplore the depths to which Nazi physicians have fallen.

With the 1st Army in Germany, April 23 (Delayed).—This is a personal message to my good friends in the District of Columbia Medical Society.

Today I visited the Buchenwald prison camp. I visited the castration ward. I saw the hanging chamber. I saw the typhus experimental clinic.

In Washington three months ago skeptics asked me, "Did you ever see a Nazi atrocity?"

The answer is now double yes!

I've seen Buchenwald.

It is near Weimar, the town of Goethe, Schiller and the first German republic. Three miles out of town is this terrible Buchenwald.

Here Nazi physicians—shame on the name of medicine—infected human beings with typhus and killed a few each day to determine the day-after-day effect on the liver, kidneys and the heart muscles.

Here they castrated men.

A few miles away in the women's concentration camp they removed ovaries. They transplanted the female glands to the male and the male to the female to determine what makes sex—can a woman be made a man, a man made a woman.

Two years ago in England I waited in the night for the return of the first Canadian bombers

from a mission to Essen. The first man to leave the plane was a French Canadian. He said:

"The good Lord, Jesus, how does he allow things like this."

My reaction today was Lord Salisbury's letterhead: "Lord Jesus come quickly."

More than a week ago American troops first entered the concentration camp at Buchenwald. They found 21,000 starving, 3,000 at the point of death. For the first few days, despite all remedies, the death rate was 100 a day. They could not hold even water on the stomachs. The only possible way to save lives was by transfusion of blood.

Now, says Colonel William Williams, former professor of physiology at the University of Texas and later a prominent physician in Austin, the death rate has been cut to 30 a day largely due to transfusions.

Buchenwald is one of the great concentration camps, better than most, say the inmates. There is no logic to it. There is no logic to anything Nazi. Men were brought here to work in the V-2 rocket bomb factory, but by deliberate policy were starved to death.

The death quota was 80 each day. If 80 did not die from starvation, the difference was

killed. The weakest were offered a choice—death by an injection of formalin in the veins or hanging themselves with the aid of SS men, who would mercifully club out their brains if they kicked too much at the end of the rope, so that their suffering from choking was not too prolonged.

I have seen roads littered with the rotting bodies of our own poor boys in Normandy. Still I can't attempt to describe Buchenwald—even a week after.

Lots of reporters came to Buchenwald before me. I went there today intending to write a cold scientific story on wholesale starvation. But Maj. Joseph Andriola of New York took me through the children's ward set up by the Army Medical Corps and into the castration ward where 3,000 men were castrated in the last few months—and somehow science seems far away.

When Colonel Williams took over Buchenwald he found 3,000 dying. He estimated that it would require 30 days without food and only occasional sips of water to bring a healthy adult man to such a condition. I found living corpses on the floors. "Looking in their eyes is like looking into a puddle of muddy water," said the Colonel.

Even a glucose injection in the veins was too much of a strain for the dying. Their condition was like shock after an operation. The former physiology professor calculated what blood was needed. He calculated the elements of food for keeping a man alive primarily to make blood. So the poor devils within a few minutes of death by starvation were given a pint of whole blood donated by people in England and America.

He feared that to give them more than a pint would cause convulsions. The effects were remarkable. Living corpses in a few hours became alive.

I saw a man today—skin drawn over bones. Twenty American doctors are working day and night to keep the poor devils alive—especially the children, mostly Polish Jews whose parents were executed in the gas chambers.

One 12-year-old was called "Gangster" because he boasted that his uncle is a member of the Capone gang in Chicago.

I entered this camp with two woman reporters. I was taken alone through the castration ward where 30 men recently operated on said they were due for gas-chamber deaths in a few days when the Americans came. They had served the purpose of sex experiments of a crazy Nazi doctor.

I was taken to the hanging chamber. There was no gallows. A man who preferred this type of death was allowed to put the noose around his own neck. He was then pulled up and choked to death.

I was told the formalin vein injection brought on a very painful death and that most of the victims preferred hanging themselves. In the walls behind the noose were marks of fingernails where hanging men had scratched in death agony before the clubbing.

As for typhus experiments, said Colonel Williams, "I don't think I will ever want to experiment with dogs again. At the University of Texas we used to do that but then we would kill them with an ether injection in the veins. It seems so different when I see men used the same way."

One good thing about Buchenwald—800 children seemed in fair physical condition due to the fact that their elders had given them all the food possible and a child needs less. They were playing games when we entered the building, like children on Washington street corners.

Among the prisoners were 60 Polish, French and Russian doctors. They said the job was hopeless since the starving were beyond taking even the simplest treatment.

It was hoped that the typhus experiments with human rabbits might have some value, but all the records were destroyed. Good friends of the District Medical Society, I hope you have a little confidence in me. Please believe my story on Buchenwald. I have tried to understate. My last reaction was:

"Lord Jesus, come quickly."

THE SURGICAL TREATMENT OF HYPERTENSION

With occasional exceptions, it is generally admitted that the medical treatment of essential hypertension is inadequate. This fact has given considerable impetus to the investigation of treatment of the disease by surgical methods. For the most part, these have had as their intention the interruption of sympathetic innervation of the visceral blood vessels. In reports on the use of these methods, the impression has obtained that the results from surgical treatment are good, although a basis for evaluation of surgical vs. medical treatment has been difficult to devise.

Woods and Peet¹ have compared the results of surgical treatment of hypertension in a group of 76 patients with the careful statistical study made by Wagener and Keith² of the results of medical treatment. In general, the comparison strongly favors the surgical method. Unfortunately the 2 groups are not strictly comparable in that the studies depend on a classification of hypertension according to the degree of retinal pathology and without regard for the fact that the patients in the medical series were presumably unselected while those in the surgical series were selected. However, the criteria for selection of a patient for operation were not exceptionally rigid. In brief, they were as follows: age: under 60 years, preferably under 50; renal function: blood N.P.N. under 45 mg. per 100 c.c., urine concentration above 1.012, and urea clearance above 40 per cent of normal; cardiac status: a compensated heart.

The surgical technics have varied from partial to total or near total denervation of the splanchnic bed, to total or near total sympathectomy. It has seemed that the more extensive operations have been more effective.^{3,4} This fact has led

Smithwick⁵ to adopt lumbodorsal splanchnicectomy for the relief of hypertension. A trans-diaphragmatic approach is used, and the great splanchnic nerves are removed from the semi-lunar ganglion to the midthoracic level or higher. In addition portions of the sympathetic trunks are removed, varying from a minimum of the tenth thoracic to the first lumbar ganglions inclusive to a maximum of the sixth thoracic to the third lumbar ganglions inclusive. The report⁵ of the first 156 patients treated by this technic is quite enlightening. A formal statement of the criteria for selection of patients for operation is not given. However, it is implied that the patients should be relatively young (perhaps under 45), that renal function as studied by the intravenous P.S.P. test should be fairly normal, and that the height of the blood pressure before operation should be carefully evaluated according to a standard technic, including the response to rest, sedation, and stimulation by cold. The extent of retinal pathology, abnormalities of the electrocardiogram, and variations of the urinalysis from normal apparently have been disregarded.

The results reported by Smithwick are very encouraging. The operative mortality was 2.8 per cent. The patients who survived the operation have now been followed from 1 to 5 years. Results that seemed certainly significant were obtained in 61.5 per cent of the patients, probably significant in an additional 17.9 per cent, and insignificant, in so far as the effect on hypertension was concerned, in the remaining 20.6 per cent. A very important finding in this study was that the outcome of operation was best for patients having narrow pulse pressures (less than one half the diastolic pressure), next best for patients with wider pulse pressures (equal to or up to 19 mm. more than one half the diastolic pressure), and poorest for those with the widest pulse pressures (20 mm. or more greater than one half the diastolic pressure). Uniformly better

¹ Woods, W. W., and Peet, M. M.: *J. A. M. A.*, 1941, 117, 1508.

² Wagener, H. P., and Keith, N. M.: *Medicine*, 1939, 18, 317.

³ Grimson, K. S.: *Internat. Abstr. Surg.*, 1942, 75, 421.

⁴ Smithwick, R. H.: *Modern Concepts of Cardiovascular Disease*, vol. 13, Dec., 1944.

⁵ Smithwick, R. H.: *Arch. Surg.*, 1944, 49, 180.

results were obtained for women than for men. Apparently therefore the pulse pressure and sex of the patient are important factors in predicting the effect of surgical treatment.

As a part of the surgical technic, Smithwick has explored the kidneys and performed a renal biopsy. He has reported⁶ that it is the rule to find little evidence of gross renal pathology. Furthermore, detailed studies⁷ of the renal biopsies from the first 100 consecutive cases indicate that the majority of living hypertensive patients have little if any renal vascular disease. These findings are strong support for the idea that renal

⁶Smithwick, R. H.: *Modern Concepts of Cardiovascular Disease*, vol. 14, Jan., 1945.

⁷Castleman, B., and Smithwick, R. H.: *J. A. M. A.*, 1943, 121, 1256.

ischemia and/or renal vascular disease do not necessarily antedate the development of clinical hypertension. They are a further stimulus to pursuit of the modern concept that lumbodorsal splanchnicectomy is a useful adjunct to the medical management of essential hypertension.

It is to be hoped that the investigation of the surgical treatment of hypertension will proceed with the same critical and scientific attitude that Smithwick has adopted. Obviously, it is not a method for casual trial. In addition, it must be remembered that the results so far reported do not justify the expectation that the method offers hope of benefit for the majority of patients with essential hypertension.

H. H. H.

INTEGRATED HEALTH PROGRAM FOR METROPOLITAN AREA

By "the little town of George on the Potomack" was the site selected toward the end of the eighteenth century for the capital city of this nation. Down the river a few miles was the town of Alexandria.

It is a far cry from that day to the present, with the city sprawling out over five other political jurisdictions in addition to the District of Columbia: Montgomery and Prince Georges Counties in Maryland; and Arlington and Fairfax Counties and Alexandria City in Virginia.* In these areas are the homes of those whose daily stint may be performed in any or all of the six jurisdictions but in the District of Columbia predominantly, and the total population numbers about 1,260,000.

The interests of one part of the area may impinge on those of another and there are some interests in common to all sections. In the field of health this is also true. No one of these geographical parts is susceptible of complete operational isolation. To think it is leads to duplication and costly non-coöperation. If this

costs more or if we get less at higher cost, the citizens pay the bill in taxes, contributed funds and in other ways.

For example, there have grown up in this area five different Community Chests, one in each of these political jurisdictions (except Prince Georges County, which is included in the Washington Community Chest). In ordinary times this involves five separate campaigns (and organizations) working largely on the same set of people and at the same time. This would seem to run counter to the original Community Chest idea, that one solicitation annually would do for the great bulk of worthwhile projects supported by contributions.

Fortunately, for the duration of the war all of these Community Chests (except Alexandria City) have placed themselves under one Community War Fund, and that has for that period and to some extent simplified the matter.

The recently discussed question of borderline practice of physicians emphasizes the necessary intermingling of interest within the metropolitan area.

Hospitalization, too, presents some observa-

*This is the area the Washington Board of Trade includes in the metropolitan trade area and in its postwar planning survey.

tions about a metropolitan area. A ring of small hospitals has been constructed in the periphery of the area. The proponents of this idea argued that it would relieve the bed shortage in the more central hospitals. The impression prevails that these smaller hospitals in the main have been operating far below capacity, while crowding in the larger hospitals has been affected very little.

The fallacy in the reasoning lay in the fact that hospitals do not treat patients—physicians do that. Sponsors of these hospitals argued that physicians would gravitate to these small institutions but this force of gravity did not materialize in the degree predicted.

Meanwhile, while two central hospitals are being rebuilt and expanded, six other hospital construction projects are seeking support and a place in the picture. The public in its enthusiasm for new structures in local neighborhoods may also forget that hospitals do not treat patients.

These three examples could be supplemented by numerous others in the health field and all would point up the desirability of sound community health planning on the basis of the whole metropolitan area.

The newly reorganized Washington Metropolitan Health Council may point the way to better inter-area understanding and planning. It has started out on this basis and comprises

in its membership valuable members from each of the six political jurisdictions. It has the support of all the city and county health officers in the area as well as that of the State Health Commissioners of Maryland and Virginia. One of its aims is to promote "an awareness of each other's programs" and this should lead to better integration and cooperation.

The Council's coming health and hospital survey* should blueprint the actual needs of the area in such a way that those who foot the bill may be assured of effective use of funds without waste. For one may be sure that without such planning, costs will be higher than they ought, services will be less comprehensive than they might, and needless duplication will exist.

Even the Scriptures had a word for it: "No man liveth unto himself and no man dieth unto himself."

H. P. R.

*This survey comes at a time when two other important surveys are on the docket. The Council of Social Agencies is starting a general survey of welfare agencies of the area at about the same time. On May 15 the Board of Trade will release the report of their surveys of (1) "Postwar Plans of Metropolitan Residents" and (2) "Estimated Postwar Construction, Replacement and Repair; and Postwar Employment." These Board of Trade reports cover the metropolitan area and have already been declared by the National Committee on Economic Development to be one of the best in the country.

LAY DIAGNOSIS

There seem to be certain subjects of a medical nature upon which many a layman is ready to express an opinion more or less dogmatically. The readiness, it may be noted, is usually in inverse proportion to the clearness with which the topic is generally recognized as medical, and sometimes as well to the degree to which the phenomenon in question is understood. Perhaps both of these factors operate in the naïve assumption that a jury of non-medical men and women has the highest degree of intelligence of

any body for passing on the need of a patient's commitment for care in a mental hospital.

Time was not so many years ago in the District that the jury was called upon to decide all cases of commitment, a barbarous practice indeed, from the point of view of the patient and his family. Now that questionable privilege is reserved for those who demand it.

An interesting illustration of the pranks that the judgment of twelve good men (and women) and true can play was furnished recently in a

hearing in the District Court. Briefly, a junior Naval officer, some months since, while serving on a merchant vessel in Mediterranean waters, developed the delusion that he was being spied upon, that the vessel was in the hands of enemy agents, that the ship and cargo were about to be turned over to the Nazis, and that the only way to prevent this calamity was to destroy the ship and crew—whereupon he discharged his revolver into the ship's magazine! (Fortunately, the intended explosion did not take place.) He was certain that his resulting hospitalization was unwarranted, and that it represented a plot against him in which the President was directly involved; in fact, he was sure that the President had made a pact with Hitler, and he therefore planned to bring court-martial proceedings against the President.

These delusions, so patently absurd as presumably to appeal only to a seriously and

dangerously deranged person, were testified to not only by the physicians of the hospital and of the Mental Health Commission, but the patient himself. What process of reasoning or the reverse was followed by the members of the jury we shall probably never know; at any rate, the jury could not arrive at an agreement as to whether the patient was of sound mind and a danger to himself or others!

When it is proposed to quarantine a patient with scarlet fever or smallpox, or to send a leper to Carville, no jury is impanelled—those conditions are generally recognized as medical problems, and the opinions of physicians are respected as authoritative. It is to be hoped that the day may come when mental disorder ceases to be treated in a manner similar to crime, and when admission to mental institutions may be voluntary or, if under compulsion, is decided as a medical matter.

W. O.

In and Out of Focus

BY THE OBSERVER

The Answer Is Always the Same

Many physicians are erroneously of the belief that only those far to the left advocate change in medical practice. They usually classify them as "left-wingers" or long-haired radicals. It may be news to these physicians that this is far from the truth, for even those right of center, whom many of the medical profession look upon as their friends, take the position that organized medicine must offer an adequate health program, otherwise it will be done for them.

This is not merely talk. Time and again officials in high places have expressed themselves along this line. For example, there is a United States Senator from a midwestern state who is known throughout the country as a leader of

the conservatives. Even he, when he was consulted by a group of medical leaders, told them frankly that what the medical profession should do was to sponsor health legislation of which it approved. That if it did not, the Wagner-Murray-Dingell Bill, or some similar legislation, would undoubtedly be enacted. The group seemed impressed by the Senator's statements but nothing came of his suggestion.

About two months ago this same group called upon one of the top-ranking public officials in Washington. The purpose of the visit was to ascertain the official's views on medicine, especially the controversial issues relating to the distribution and costs of medical care and the health legislation before the Congress. This official said frankly that he did not favor "socialized

medicine" but that health facilities in many communities were inadequate. He asked them for their program, but they had none, and the conference ended.

A week before these lines were written, your Observer happened to be in a Washington hotel where he accidentally met one of the promising young political leaders of this country. He introduced himself and a highly interesting conversation followed. Among other things, this eminent young man stated emphatically that he was not in favor of "socialized medicine," which he defined as a government system of medical care, but said that there were unmet medical needs. He hoped the medical profession would see that they were provided for.

These are just a few of similar responses from responsible public leaders. All of these men were friends of the medical profession. Not by any stretch of imagination are they radical. How long will medical leadership fail to take cognizance of the fact that it is their friends who are concerned lest they do not come forward with an adequate program? It is not enough to boast of the fact that several state medical organizations are doing a good job. Many of them are, and some are not. What is important now is that the American Medical Association offer a national program in which all state medical organizations will be asked to cooperate. Doing less than this will not be enough.

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What Will California Do?

In the last issue of the MEDICAL ANNALS your Observer commented on the compulsory health insurance bill introduced in the California State Assembly late in January. He reported that Republican Governor Earl Warren was leading the fight for its enactment. Since that time there have been important developments in the struggle between the California Medical Association and the Governor.

According to a bulletin issued by the Public Health League of California on April 5, the

Assembly Committee on Public Health refused to give favorable consideration to two compulsory health insurance bills, one being the Governor's, the other having been introduced by the C.I.O. Both bills were vigorously opposed before the Committee by representatives of medicine, hospitals, business, insurance, veterans' organizations, and other groups. The principal witness for the Governor's bill was Nathan Sinai, Dr. P. H., Professor of Public Health, University of Michigan. For the C.I.O. bill were Professor Samuel May of the University of California and Paul Pinsky. The Committee voted 7-3 against recommending the adoption by the Assembly of these bills.

Proponents of the bills served notice that they would move to override the Committee action and withdraw the bills from the Committee. This was thwarted, however, when the majority of the Assembly voted against withdrawing the bills from the Committee 42-34. Despite these setbacks, the fight goes on, and it is announced that Governor Warren and the C.I.O. are introducing a compulsory health insurance bill in the California Senate eliminating the most controversial provisions of the previous bills.

No physician needs to be told that what happens in California is of the greatest importance to the medical profession throughout the country.

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Borrowed from Yesterday?

Not so long ago your Observer was looking through the books in the Medical Society's library for historical material. In the course of this browsing he came across several volumes of *The National Medical Review*, a journal edited and published in the Nation's Capital during the 1890's by Dr. Charles H. Stowell. These would have been of no particular interest to him had it not been for the discovery that Dr. Stowell conducted a column not unlike this one. He called it "The Editor's Table." This was a half century ago, and your Observer hastens to credit Dr. Stowell with doing a good

job. He, too, discussed informally the many medical problems of the day, such as antivivisection (still a live subject), the use of antitoxin for diphtheria, and physicians and the press. He also devoted himself to the lighter side of medicine to the undoubted enjoyment of his readers.

Examples of Dr. Stowell's literary efforts should be of interest to those who peruse this column. Some of his views are surprisingly modern. Under the caption "No Reporters Allowed" he writes:

"We introduced a resolution to the effect that a reporter from the *Post* be allowed to be present, which was adopted. But that part of the resolution which related to reporting the Discussions of the paper also was so amended that a day or two would be required before it could be given to the press. Of course, no live paper would take it when thus cold. At a meeting prior to this, a resolution to allow reporters to be present was overwhelmingly voted down. This is not in keeping with the times. If an executive session is ever necessary, it can be easily obtained; but there is no necessity of trying to make the public believe we are surrounded by such a high fence. 'We do not want any of our patients to know what we think of this subject.' This is about the only argument presented. The Editor of the *Medical Record* has recently said that 'There is nothing specially mysterious or sacred about the discussions in medical societies, nor is there any good reason why they should be held in secrecy. As a matter of fact, they are usually too technical to have any general interest. But we see no reason why the public should not hear what physicians say in open discussion about matters that concern the general welfare. If medical societies degenerate into occasions for bickering and quarrelling, and the airing of personal grievances, their sessions might well be made secret. But there is no other good reason.'"

On the humorous side, he discusses "Why Is Man Bald?"

"A recent writer says this is due to the habit of clipping or cutting the hair, and at once proceeds to give a most ingenious theory to substantiate his claim. He then warns women against wearing their hair short for fear of baldness. The question of the cause of baldness in men has been a subject of many a medical sermon. After much thought on the subject, we have come to the

conclusion that this affection is due to the fact that man votes. The intense excitement at election time causes a rush of the animal fluids to the top of the head, where, in their attempt to escape, they act as a violent poison to the hair follicles. We cannot now remember of having seen a man who was very bald, who did not vote; therefore, there is but little doubt that this is the cause of the whole difficulty. It is with a feeling of deep sadness and sincere regret that we are obliged to warn our ambitious sisters against ever casting a vote, lest they lose this adornment. We have an additional proof of the truth of this theory in the fact that a large number of those women who are now trying to obtain the privilege of voting have lost a good part of their hair simply in the attempt, and now go about with it clipped at the same length of the new male voter of twenty-one."

As to the state of affairs in the Medical Society, he says:

"The Medical Society starts out with great prospects. The attendance is good and the interest great. There is not a more prosperous body of medical men in the country, and certainly not a better natured one. In the five years we have been a member we have not seen a single drop of bad blood. To be sure men have been in earnest, but no words have been spoken hot enough to produce an appreciable amount of spleenytotoxin. If troubled with excessive irritability, come into the pool, brother, and be healed."

Like most writers he was anxious to know what his readers thought of him. However, unlike the majority of them, he was frank in saying so.

"If you think well of this journal, tell us so. Do not be afraid it will cultivate our vanity beyond an amount which will be for our good. After we are through with journals and all other labors, it will give no comfort to us if you tell our friends what a good journal we conducted.

'If you love me, tell me so;
Wait not till the winter hours
Heap with snow drifts all the flowers;
Till the tide of life runs low;
If you love me, tell me so!'"

These samples should encourage our readers to want to know more about this Dr. Stowell and his writings. Your Observer has enjoyed turning back the pages of time, and he has rediscovered what he already knew, that there is nothing new under the sun.

Tough Sledding for Civilian Physicians

No matter how heavy their wartime burdens, most civilian physicians hesitate to comment on them for fear of being misunderstood. They know that no matter how long their hours or how difficult their tasks, they cannot be compared with those of their colleagues on the fighting fronts. So they are silent on the subject.

The fact is, however, that the practices of physicians in urban centers have increased to a point where not a few are working beyond the limit of their endurance. One needs only to observe them to realize this fact. It is true, of course, that their incomes have increased in proportion to their practices. But if the physician is approaching middle age or has passed that period, he may be paying very dearly for the additional income which he is receiving. It is to be hoped that many of them will live to enjoy their earnings.

Your Observer has talked to a number of physicians who are sensitive to the suggestion that their lot is "a bed of roses." They are fully appreciative of their good fortune, but they are not too sure that it is best for them in the long run.

Dr. J. Phil. Edmundson, the sharp-tongued Catalyst, needles his fellow practitioners on an already sore spot in the March 10 number of the *Jackson County Medical Society Weekly Bulletin* (Kansas City, Missouri).

"We rarely enter the elevator at the end of office hours," Dr. Edmundson says, "and ask a physician acquaintance how he feels, than he immediately pulls a long face and groans: 'I'm tattered!' Several of these chaps found it none too easy getting a start only a few years ago. Today they have big practices, but constantly complain of how many patients they were forced to see before calling it a day. They are good men and deserve the success they have attained, but their attitude seems to us very much like looking a gift horse in the mouth. Personally, we are very grateful for being kept busy and for possessing a long memory. Not so many years ago we got very, very tired—waiting for business!"

"We once knew a most successful quack who, because of a certain charm and a lot of ready—if misdirected—

energy, amassed a tidy sum. We have no desire that you emulate his tactics, but on one point, at least, he was psychologically sound. Having two male assistants and numerous office nurses and technicians, he had but one rule which he insisted upon being followed to the letter: No one must ever admit that he was tired. He said it had a demoralizing effect on his patients, and quoted that classical definition of a bore: 'A bore is one who, when you ask him how he feels, tells you!'"

"So you are tired, eh? Yow Yummm!"

The New York State Journal of Medicine,* however, takes a more serious view of the matter.

"It is becoming apparent that the increasing load upon the shoulders of civilian medical practitioners is reaching a somewhat dangerous point," the *Journal* states. "This year should mark the beginning of the really tough sledding for most physicians. No replacements for civilian doctors who become ill or die seem to be possible. Even in the event of a German defeat . . .

"In a communication to this *Journal*, Lt. Col. Harold C. Lueth, M.C., Army Service Forces, says 'Community medical care in the future will undoubtedly be impaired unless additional replacements are found for the losses of civilian practitioners. Any replacement scheme will, of course, depend upon the number and speed at which medical officers are discharged or released from active military duty. This problem, like the first one, has not been definitely decided and must await future developments.'

"In addition, the withdrawal of nurses for the armed forces is operating to require more of the doctor's time to complete his hospital work. And the inability of the hospitals to care for many people is increasing the necessity for house calls, home care of illness, and putting a still further drain on physicians' energy and time.

"Apparently, little relief can be anticipated in the near future, from any of the ordinary sources of replacement.

"It seems timely, therefore, to consider what might be done, not by choice but of necessity, to meet the situation, to make the present physician population last a little longer and to extend its services to more people.

"First, there is the matter of meetings. Committee work of the various societies is still far too heavy, and prolonged. It is shared by too few men. Night meetings cut into time for rest, which is becoming more and more a necessity. Something can be done about that.

"If rest is a necessity, relaxation is even more imperative. It is something few physicians ever enjoy.

* December 1, 1944.

If a physician is at home, the telephone prevents it effectively; if he is away from home, then worry over the case that is not doing too well shatters it. There is no escape from the prison of responsibility, individual responsibility, responsibility that sends blood pressure up, and which drives inexorably. Can anything be done about that? We doubt it. Except that group practice in some measure provides a kind of relief by providing opportunity for more frequent consultation, and thus a sharing to some extent of responsibility. In some places night calls are handled through the local hospitals and thus a measure of relief is afforded by a better distribution of this particular responsibility. These matters are here brought up in the hope of directing the ingenuity of the profession to the possible experiments, which may avoid needless drains on definitely limited energy and time, without sacrifice of quality of services.

"Many possible experiments have not yet been fully explored, probably because the necessity for them has seemed somewhat remote. But the time appears to be fast approaching when they must be considered locally, throughout the state, and nationally. It is better to begin too soon than too late."

There you have it!



"...the Most Promising Approach" What will the thousands of physicians who entered the armed forces directly from their internships or residencies, and who have never been in practice, do upon their return to civilian life? Will they enter private practice? Or will they seek the security of a salaried position? If they are offered permanent, full-time positions by the Federal Government, will they accept? In other words, will these young physicians be receptive to a Government system of medicine? These questions must, of course, remain unanswered until after the war, although there are some straws in the wind which would indicate that most of them would prefer private practice.

Dr. Victor Johnson, Secretary of the Council on Medical Education and Hospitals of the American Medical Association, had something to say on this subject in a convocation address at Boston University School of Medicine last September.

"Every returning soldier will face his own peculiar problem," Dr. Johnson said, "in his adjustment from a life of hardship where every decision was made for him to a life less hard but requiring him to do the deciding. Medical officers will face their own special problems.

"When the war ends, thousands of physicians will have known no other form of medical practice than that of completely socialized medicine. The group practice of medicine is not socialized medicine. Neither is salaried medical practice, or hospital or sickness insurance. Socialized medicine is a system in which all doctors are paid from tax moneys, no patient pays his doctor directly, and all patients are provided with free medical care. This form of practice is necessarily the rule in the armed forces. Army and Navy medicine is completely socialized, and is the form of practice of one-third of the active physicians of the United States today.

"In the armed forces, everyone who needs medical care must get it. The economic status of the patient is never even considered. The only criterion for the best of treatment is the need of the patient. Every resource of medical science must be employed when available and indicated: plasma or penicillin, surgery or psychiatry, regardless of cost. No obstacle can be too great to surmount, whether it may require eight natives to carry a single wounded soldier to a medical station in the Owen Stanley Mountains, or a fleet of air transports to carry the injured from the fields of France to a hospital in England.

"There is no doubt that wartime experiences of physicians and of patients will stimulate increased efforts toward the provision of improved medical care for everyone, but without that necessary total regimentation that must obtain in the armed forces. Such regimentation is complete, in every phase of the life of both the doctor and the patient. The patient is ordered to appear before the doctor, and the doctor in turn may order the patient to the hospital. This has not been possible in civilian life."

There are several interesting things about Dr. Johnson's statement. For example, his definition of socialized medicine varies considerably from that of many other medical leaders. To socialize is defined in your Observer's dictionary "to put into control of a group rather than of an individual." What Dr. Johnson describes as socialized medicine is usually termed "state medicine." It would help considerably if there were general agreement in the medical profession on this point.

Dr. Johnson also says that wartime experiences will undoubtedly "stimulate increased efforts toward the provision of improved medical care for everyone." As to how this will be accomplished he says:

"Changes will come. You will be involved in them. In part, you will direct them. In so far as you exert influence, you should be impelled by the impartial spirit of inquiry that served you so well in your pursuit of the truth in the medical sciences.

"We must recognize the extreme complexity of the problem. To state that doctors are attracted to cities because they can make more money there is a gross oversimplification. Cities provide the essential tools for the practice of medicine, which have been many times multiplied—X-ray equipment, electrocardiographs, other laboratory facilities, consultation services, and, above all, hospitals.

"The economic level in many rural communities, and in many counties in the United States, makes it impossible for those communities, unaided, to provide either doctors or the necessary facilities for doctors to carry on their work. It seems clear that hospital facilities will be lacking or will remain at a substandard level in many rural communities in the United States unless there is increased state and federal aid for hospital construction and equipment, the organization of clinics and the development of traveling clinics, to be operated under local control.

"But even if all this were provided for the country physician, problems of distribution of medical care would remain. The doctor demands, in common with his civilized fellows, a life with stimulating social, intellectual and cultural contacts. Good schools, homes, churches, music and comradeship may loom as large in his selection of a community to practice in as income, X-ray facilities or hospitals.

"The distribution of medical care is only one aspect of the larger problem of elevating the general economic level of large numbers of our population in peacetime. If unemployment is kept as low as now, and production is maintained at the present level after the war and dedicated to the welfare of the people, the problems of distribution of medical care will be greatly diminished.

"Difficult though these problems are, they must be attacked. Here, as in science, experimentation provides the most promising approach."

He mentions experiments such as the California Physicians Service, Prepaid Medical Service in Connecticut, and the Michigan Medical Service.

"As in the fields of the more exact sciences," Dr. Johnson warns, "these experiments in medical sociology are likely to turn out to be poorly conceived, in some instances, and often the results may be difficult to interpret. But the all-important fact remains: experiments in the distribution of medical care are in progress, and we may hope that they will be as fruitful as those that provided insulin for diabetes, liver for pernicious anemia and penicillin for infections.

"We are impelled to continue experiments of this kind, as well as experiments in carrying patients to the doctors with adequate modern facilities, recalling the air transport of the wounded in battle, instead of struggling to provide doctors and hospitals for every community. We must experiment with traveling clinics and the closer integration of diagnostic, hospital and expert consultation services. Above all, we must experiment rather than design blueprints in the skies; we must follow the methods of science, not the promptings of emotions."

Dr. Johnson is a thoughtful and forward-looking physician. Not so long ago he appeared before a Congressional committee where he created a most favorable impression. If given the opportunity, he will undoubtedly demonstrate outstanding qualities of leadership.



Minnesota's Enabling Act

The medical profession of Minnesota has flirted with the idea of prepaid medicine much longer than most states. Recently it joined the ranks of experimenters by introducing an enabling act in the legislature permitting the establishment of nonprofit prepayment medical service plans.

At the time this is written the bill has not been enacted. If it becomes a law, there will be keen interest throughout the country in its application, for it has some unique features.

The purpose of this legislation as set forth in the opening paragraph of the bill is "to make possible a wider and more timely availability of medical care, thereby advancing the public health and the science and art of medicine in this State."

The essential provisions of the bill are:

Nonprofit medical plan corporations shall be

organized by not less than 21 persons, all of whom must be legal residents of the state and duly licensed doctors of medicine.

The corporation "shall have the right to establish, maintain and operate a voluntary non-profit medical service plan, whereby the services of duly licensed and registered doctors of medicine are provided in the manner . . . specified at the expense of . . . [the] corporation to persons who become subscribers."

The corporation shall not be subject to the laws of the state relating to insurance.

There shall be no cash indemnification by the corporation to the subscriber.

The amount of capital with which the corporation will begin business shall be not less than \$25,000.

Every subscriber shall have free choice of physician who is to treat him. "No employee, agent, officer or member of the board of directors of any such corporation shall directly or indirectly influence or attempt to influence any subscriber in the choosing and selecting of the doctor of medicine who is to treat him."

The benefits to which a subscriber is entitled "may be rendered in another state or country, provided such services are rendered by a duly licensed doctor of medicine in such other state or country."

Prior to the drafting of this bill a poll was conducted throughout the state. The poll revealed that 83 per cent of the people of Minnesota favored some form of medical service similar to the Blue Cross program of hospitalization. Forty-eight per cent favored government sponsorship, 28 per cent medical profession sponsorship, 21 per cent were undecided, and 3 per cent had no opinion.

Minnesota Medicine states that "the geographical breakdown shows farmers are a good deal less inclined than city dwellers to approve a monthly payment plan like those incorporated in hospitalization contracts, probably because they participate less in group hospitalization."

Comments by newspapers on the legislation

have been favorable. One paper, the *Minneapolis Star Journal*, was especially commendatory as regards the appearance of Dr. A. W. Adson, Chairman of the Sickness Insurance Committee of the Minnesota State Medical Association. "Testimony of Dr. Adson of the Mayo Clinic Friday before the Minnesota senate health committee," the *Journal* says, "must have struck a responsive chord in many a breast. Gist of his testimony was that 'medical care should be extended to all classes regardless of their economic status.'"

Minnesota Medicine warns that "enabling legislation is just a step in the direction of providing prepaid medical service. The next step will have to come from the medical profession, itself, to develop an organization that will put the plans into operation."

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Committee on Medical Care Makes Progress

Bulletins issued in recent weeks by the Society's Committee on Medical Care have stimulated considerable discussion. Apparently they have served the purpose for which they were intended, to arouse interest and to provide our members with a background against which to consider the program which will be offered by the Committee. The reaction on the whole has been favorable. A few thought the material elementary, but a majority who expressed themselves agreed it was just what was needed.

A study of 10,000 cases hospitalized in Washington in the year 1940 will be completed long before these comments appear. The purpose of this investigation is to ascertain the percentage of surgical and obstetrical cases and the procedures adopted.

The Committee should be prepared to present its plan to the Society sometime in June. Its development has been a laborious process, and the Committee deserves the highest commendation for its faithfulness.

Another phase of the Committee's program has been its investigation of diagnostic clinics.

Mention should be made of the fact that there are two subcommittees of the Committee, one on prepaid medicine and the other on diagnostic clinics. The latter made a first-hand study of The Diagnostic Clinic at Johns Hopkins Hospital some months ago. This was followed by conferences with officials of the United States Public Health Service. It was thought for a time that the Society itself might establish such a clinic. However, an effort is now being made to interest the two teaching hospitals, George Washington and Georgetown, in establishing diagnostic clinics. What the final decision will be should be known before too long.

So it can be seen that the Society's Committee is making progress though at times it seems slow. Committee members themselves have sometimes chafed at the pace, which they have found impossible to accelerate.



The Navy Needs Doctors

The Secretary of the Medical Society recently received a letter from Lieutenant Commander John W. Ridenour, Jr., M.C.,

U.S.N.R., of the Office of Naval Officer Procurement, emphasizing the great need for Naval medical officers. "The fact that the Army has announced the suspension of procurement of physicians," Commander Ridenour writes, "should not be interpreted to mean that the Navy is in the same position. We must face the truth; our rate of casualties has been increasing in recent months. Our men must have much-needed medical assistance." He then points out the need for 3,000 additional doctors immediately and makes an appeal to members of the Society to assist him in every way possible. He says he fully realizes the drain which has been imposed upon civilians and that in many sections of the country the shortage of doctors is acute. "Hard as this shortage is on tens of thousands of people, yet thousands of people must be asked to make sacrifices in medical care for their friends, relatives, and countrymen whose need for medical assistance is so great."

"All over the world Navy doctors are exposed to a training in medicine and surgery which is not only giving them a splendid chance patriotically to serve their country, but at the same time, an opportunity to learn the most advanced techniques of the profession, working with men whose contribution to the field of medicine will be great both during and after the war. It is, therefore, earnestly requested that every physician give conscientious support to the medical needs of his community, to his responsibility to that community and to the war itself, and see if the best path for him to follow is to seek a commission with the U. S. Navy."

Physical requirements have been modified so that physicians are now acceptable up to the age of 60. Older physicians are assigned to hospitals, dispensaries and other Naval activities ashore. Physical standards have also been lowered so that in certain organic conditions waivers can be granted for defects which were formerly disqualifying.

Physicians who wish to be commissioned in the Navy should communicate with Commander Ridenour, whose office is at 1320 G Street, N.W., Washington.



Your Medi- cal Journals Needed

One of the many tragedies of this war has been the destruction of medical libraries. Many valuable and irreplaceable collections of books and periodicals have been wantonly destroyed. The best that can be done under the circumstances is to supply these libraries where possible with duplicate publications.

Aside from devastated countries there are those less favored than ours. There are, for example, the Latin American nations where medical libraries are inadequate and need for up-to-date scientific periodicals great.

The Medical Society recently received a communication from the Army Medical Library, which is organizing a national and international exchange for the purpose of collecting duplicate material. Foreign requests, it is stated, for such material are coming steadily from libraries in Europe, South and Central America, Australia and the Philippines. Nearly all of the libraries

desire files of standard medical publications such as the *American Heart Journal*, *American Journal of Diseases of Children*, *American Journal of Tropical Medicine*, *Annals of Internal Medicine*, *Archives of Dermatology and Syphilology*, *Surgery*, *Gynecology and Obstetrics*, and *War Medicine*. The Library is in a position to supply many of these items, but cannot continue to do so indefinitely.

The hope was expressed that physicians in Washington who do not maintain personal libraries or who do not regularly dispose of their journals through medical schools might be willing to aid the Library to meet the needs of foreign medical libraries. An appeal has been made to the Society to contact its members in regard to this matter. If members having files of the above or other periodicals for which they have no further use will deliver them to the Society's office, they will be picked up by the Library.

Here is an opportunity for physicians in Washington to come to the aid of their fellow practitioners throughout the world.



Why Organizations Fail

No organization can maintain a high pitch of enthusiasm indefinitely. Alternating periods of intense effort and comparative inactivity, it seems, are essential to its well-being. Many members weary of being kept going at too fast a pace for too long a time. They welcome a lull in activities. Yet they are most critical during the let-down. They are inclined to feel that nothing is being done and speak disparagingly of their organization. They may find fault with their leaders, forgetting that even good leadership without support is impotent.

The other day your Observer came across some semi-serious suggestions to these destructive critics which originally appeared in the *New York Telegram*. Here they are:

"Don't come to the meetings.

"But if you do come, come late.

"If the weather doesn't suit you, don't come at all.

"If you do attend a meeting, find fault with the officers and other members.

"Never accept an office, as it is easier to criticize than to do things.

"Nevertheless, get sore if you are not appointed on a committee, but if you are, do not attend committee meetings.

"If asked by the chairman to give your opinion regarding an important matter, tell him you have nothing to say. After the meeting tell everyone how things ought to be done.

"Do nothing more than is absolutely necessary; but when other members roll up their sleeves and willingly, unselfishly use their ability to help matters along, howl that the association is run by a clique.

"Hold back your dues as long as possible, or don't pay at all.

"Don't bother about getting new members. Let the secretary do it.

"When a banquet is given tell everybody money is being wasted on blowouts which make a big noise and accomplish nothing.

"When no banquets are given say the association is dead and needs a can tied to it.

"Don't ask for a banquet ticket until all are sold.

"Then swear you've been cheated out of yours.

"If you do get a ticket, don't pay for it.

"If asked to sit at the speaker's table, modestly refuse.

"If you are not asked, resign from the association.

"If you get your BULLETIN don't read it; if you don't get it complain to the secretary."

Your Observer hastens to say that fortunately most of the above do not apply to the members of our Society, and that is much to be thankful for.



1945 Assembly Cancelled

It had been hoped that the 17th ANNUAL SCIENTIFIC ASSEMBLY, scheduled for October 1, 2 and 3, 1945, could be held as planned. However, the Committee on Wartime Conventions of the Office of Defense Transportation has ruled that the ASSEMBLY, along with other meetings of its kind, is out for the duration. So, for the first time since it came into existence, the ASSEMBLY has been cancelled.

There has been some discussion of holding a substitute meeting in the Society's building,

but no definite plans have been approved. The whole matter has been turned over to the Executive Board, which will decide if anything should be offered in the place of the ASSEMBLY.



Offices for Service Physicians

At the request of the Committee on Service Physicians officials at Medical Center canvassed tenants of the Columbia and Washington Medical Buildings to ascertain how many could and would share space with returning service physicians. One hundred and forty-four responded out of some 250 physicians. Twenty-seven stated that they would share space, 117 said they would not or could not. Of the latter number, 5 said they would accept full-time

subtenants, 11 tenants for certain days, and 12 for certain hours. Eleven stated they would allow the use of their clerical force, 8 of their nurse, and 7 of their equipment.

Fifteen of the 27 physicians who agreed to share their space are situated in the Columbia Medical Building, 12 in the Washington Medical Building. Of the above, 1 was a proctologist, 1 an obstetrician and gynecologist, 6 internists, 1 a neurosurgeon, 2 ophthalmologists, 2 urologists, 1 an anaesthetist, 2 general surgeons, 1 a radiologist, and 3 otorhinolaryngologists.

Activities of the Committee will be accelerated when it becomes definitely known that a number of service physicians will soon return to civilian practice.

CHANGES IN THE NUMBER AND PATIENT LOAD OF PHYSICIANS PRACTICING IN WASHINGTON, 1942-1945

ANTONIO CIOCCO AND ISIDORE ALTMAN

Division of Public Health Methods, United States Public Health Service

This is a report on the third wartime survey of Washington's practicing physicians made by the Medical Society of the District of Columbia, the District of Columbia Procurement and Assignment Service and the U. S. Public Health Service.

The latest survey has in common with the previous two surveys^{1, 2, 3} the following objectives:

1. To obtain a complete count of the active private practitioners in the District of Columbia.
2. To estimate the patient load of the private practitioners.

In addition, the latest survey sought information on the number of physicians who employ nurses and the patient load of these physicians.

Data on the number of active practitioners have been derived from all the sources described in an earlier report¹—the card file of the District of Columbia Procurement and Assignment Service, the licensure lists, the telephone directory, etc. Information regarding the patient load of the physicians and the number employing nurses was obtained by mailed questionnaire.

NUMBER OF ACTIVE PRIVATE PRACTICING PHYSICIANS, 1942-1945

In September 1942 there were counted 991 physicians in active private practice. Six months later the number had fallen to 910, but in April 1945, 2 years after the second count, the number is still 910. However, because of the increase in the population of the District of Columbia, the number of persons per physician has risen from 838 in 1942 to 934 in 1943, and to 1,018 at present. (The latest figure is probably an underestimate since it is based on a population estimate for July 1944.) Thus, although the actual number of physicians has remained the same during the last two years, the increase in population has brought about a relative reduction of physicians available to the inhabitants of Washington.

The ratio shown above refers only to the population within the boundary limits of the District of Columbia. As has been pointed out in the previous reports, Washington is the medical center for the surrounding areas of Maryland and Virginia; i.e.,

a high proportion of the population in Montgomery and Prince Georges Counties, Md., and Arlington County and the City of Alexandria, Va., comes to Washington to see physicians. These areas have an estimated population of 384,000 and 138 active physicians in private practice, most of whom are general practitioners. If we consider the physicians and population of the whole metropolitan area then the number of persons per physician is now 1,250 as compared to 990 in 1942.

Although the total number of physicians has apparently remained constant since 1943, certain changes have taken place in the composition of the physician group. These changes are shown in tables 1 and 2.

TABLE 1
Physicians in private practice in the District of Columbia, September 1, 1942, April 1, 1943, April 1, 1945

DATE OF SURVEY	AGE OF PHYSICIANS				
	Under 35	35-44	45-64	65 & over	All ages
White Males					
September 1, 1942.....	109	282	296	99	786
April 1, 1943.....	78	226	306	105	715
April 1, 1945.....	66	229	324	92	711
Negro Males					
September 1, 1942.....	63		86		149
April 1, 1943.....	13	41	73	14	141
April 1, 1945.....	4	33	85	17	139
Females					
September 1, 1942.....	—	—	—	—	56
April 1, 1943.....	14	21	12	7	54
April 1, 1945.....	12	23	18	7	60
All Physicians					
September 1, 1942.....	—	—	—	—	991
April 1, 1943.....	105	288	391	126	910
April 1, 1945.....	82	285	427	116	910

In table 1 is summarized the age, sex and race (color) composition of the practitioners enumerated in the three periods. There has been little change in the ratio of white to Negro male physicians during the periods studied, but the number and proportion of women physicians are now greater than in 1942. The age composition of the white male physicians

deserves special comment. In the period between September 1942 and April 1943, the physicians as a group increased in age. There was a decrease in the number of physicians below 45 years of age, and an increase in the number 45 years old and over. In the 2-year interval from 1943 to 1945, on the other hand, the average age of the physicians has remained constant. This is because deaths and retirements have cut down the number of physicians 65 years and over to an extent which exceeds the loss of physicians under 35 to the armed forces. Although there are 13 fewer white male physicians 65 years or more at the most recent count, there are in total only 4 less white male physicians than before.

TABLE 2
Age and specialty of white male physicians in private practice in the District of Columbia, September 1, 1942, April 1, 1943, April 1, 1945

TYPE OF PRACTICE	AGE								
	Under 45			45 and over			All ages		
	Sept. 1, 1942	Apr. 1, 1943	Apr. 1, 1945	Sept. 1, 1942	Apr. 1, 1943	Apr. 1, 1945	Sept. 1, 1942	Apr. 1, 1943	Apr. 1, 1945
All types.....	391	304	295	395	411	416	786	715	711
General practice.....	153	129	112	155	164	149	308	293	261
All specialties.....	238	175	183	240	247	267	478	422	450
Internal medicine.....	53	46	47	47	55	65	100	101	112
Surgery.....	37	27	35	39	40	51	76	67	86
Gynecology and ob- stetrics.....	42	29	29	24	26	27	66	55	56
Pediatrics.....	25	19	15	15	17	20	40	36	35
Eye, ear, nose and throat..	32	24	26	51	48	48	83	72	74
All other.....	49	30	31	64	61	56	113	91	87

The data of table 2 point in the same direction. It is seen first of all that between April 1943 and April 1945 there has been an increase in the number of specialists. While from 1942 to 1943 the percentage of specialists among white male practitioners declined from 61 to 59, it has risen to 63 in 1945. The increase has been particularly noticeable among the surgeons and internists. Both now total more than in 1942. What has apparently happened is that the losses due to recruitment for the armed forces and to death and retirement have not been compensated with regard to general practitioners and have been overcompensated with regard to specialists.

PATIENT LOAD, 1942-45

The latest questionnaire sent to the physicians requested information concerning patients seen during the week February 12 to 18, 1945. Replies were received from 63 per cent of the physicians queried. The white male physicians who replied represented 69 per cent of the white male general practitioners and 55 per cent of the specialists. Only 37 per cent of the Negro physicians responded, but 72 per cent of the females did. The age distribution of the white male general practitioners who replied is the same as that of all such practitioners in the District of Columbia.

TABLE 3
Average weekly patient load of white male general practitioners, February 1945 and September 1942

AGE GROUP (IN YEARS)	NUMBER OF PHYSICIANS GIVING INFORMA- TION	WEEKLY PATIENT LOAD					
		Averages				Standard deviations	
		Office	Hos- pital	Home of pa- tients	Total	Office	Total
February 1945							
Under 35.....	18	97	7	34	138	63	84
35-44.....	64	102	8	32	142	53	67
45-64.....	75	106	7	31	144	76	97
65 and over...	24	49	5	21	75	44	57
All ages....	181	96	7	30	133	67	85
September 1942							
Under 35.....	26	96	8	23	127	49	66
35-44.....	58	102	10	23	135	76	87
45-64.....	43	89	7	22	118	68	90
65 and over...	29	40	3	15	58	40	52
All ages....	156	86	8	21	115	68	84

In table 3 are presented the average patient loads of the white male general practitioners according to age groups for 1942 and 1945. It is seen from the data summarized in the table that:

1. The average patient load has increased from 115 to 133 patients per week from 1942 to 1945.
2. The increase is relatively more marked among the older physicians.
3. The increase is manifested by more office and more home calls, while the average number of patients seen in the hospital has remained constant.

The increase in patient load was to be expected as a consequence of the reduction in number of general practitioners. As a matter of fact, on the basis of the 1942 data (table 10 of ref. 2 in bibliography), it was estimated that a reduction in number of practitioners equal to that observed now would bring about an increase in the average patient load to 135. It is gratifying to note how close the predicted is to the actual patient load observed.

The greater proportional increase in patient load among the men 45 years and over as compared with the younger men has resulted in altering the previously found relationship between age and patient load. One does not find any longer that the peak of the patient load occurs among physicians 35-44 but takes place later. The marked increase in the patient load of physicians 65 years and over probably deserves attention because of the effect it may have on disability and mortality among these physicians.

The average weekly patient load of the female physicians increased slightly during this period, from 86 to 90, while that of the Negro physicians diminished from 107 to 93. A greater patient load was shown by all the specialist groups except the surgeons, a finding which may probably be related to the marked increase in the number of these specialists.

The general decrease in the number of physicians has been, therefore, accompanied by a general increase in patient load. As a result, and notwithstanding a greater population, the number of services received by the population has changed little. In 1942 the average annual services for the District of Columbia population was estimated at 5.9 persons. It is now calculated to be 5.4. Considering the variability of the sample, such a change is probably not significant.

OFFICE NURSES AND PATIENT LOAD

On the basis of the replies from the physicians it is found that 29 per cent employ one or more nurses full- or part-time. It can therefore be estimated that there are approximately 265 nurses employed in physicians' offices in Washington.

The percentage of physicians having the service of nurses is 35 among the male white physicians, 26 among female physicians, and only 2 among the Negro physicians. The type of practice influences

the need for office nurses. Among general practitioners, the percentage employing nurses equals 24, and among specialists is 41, almost twice the former percentage. Physicians whose practice is limited to obstetrics and gynecology rank first among specialists in the employment of nurses—77 per cent reported that they have the services of an office nurse.

Age is also associated with the proportion of physicians who have office nurses. Among the white male general practitioners, for example, one finds that nurses are employed by 11 per cent of the men under 35, by 25 per cent of those between 35 and 44 years of age, by 29 per cent of the physicians in the 45–64 age range, and by 21 per cent of the men 65 years and over.

The employment of a nurse is obviously related to the amount of work done by physicians and thus one finds that the patient load of physicians with nurses is greater than that of physicians without office nurses. The average weekly patient load of white male general practitioners with office nurses equals 173 as compared to 120 in the case of practitioners without nurses; i.e., those who employ nurses see on the average $1\frac{1}{2}$ times as many patients as physicians who do not. While it is primarily a consequence of the demand for the physician's services, the greater patient load of physicians with nurses also is an indication of the greater activity of physicians who are assisted by nurses.

SUMMARY AND DISCUSSION

Between September 1942 and April 1943 there was a reduction in practicing physicians from 991 to 910 but in the two years from April 1943 to April 1945 the number apparently remained stationary. Moreover, the average age of the practitioners has remained the same during this second interval. The most important change noted has been a relative increase in the number of specialists and a corresponding decrease in the number of general practitioners.

These findings reveal that between 1943 and 1945 the losses due to death and retirement and to the entry of physicians into the armed forces have been exactly compensated by the entrance into practice of new physicians or the relocation of physicians from other areas. This phenomenon is not sur-

prising, for the demand for medical care in an urban community of the size and economic status of Washington must obviously attract physicians from less favored areas. The existence of two medical schools and many hospitals, in addition, assures a supply of young men not qualified for military service and who find it desirable to remain here. It would be of interest to learn if the same phenomenon is not taking place in other large urban centers. If it is, then we must expect progressive loss in medical personnel in areas not economically favorable. On the other hand, further demands from the armed services can be met only from the supply of physicians in the large urban centers.

The continued entrance of new physicians in practice in Washington in the face of further demand for physicians for the armed services points to the need for repeated periodic evaluation of the physicians in practice in relation to their availability for the armed forces. It is important to recognize that the composition of the physician population undergoes changes all the time and, in the interest of the population as well as to assist in the war effort, the essentiality or availability status of individual physicians should be reviewed fairly frequently.

Although between September 1942 and April 1945 there was a net reduction of 8 per cent in the number of practicing physicians and an increase in the population of 12 per cent, it appears that the population still receives the same amount of medical services. As the figures on patient load clearly indicate, this has been made possible only by increased work on the part of physicians. The data on patient load also point to the importance of office nurses in the amount of medical care furnished. The physicians who employ nurses have a higher patient load than those who do not. Any reduction in the number of nurses will certainly affect the physicians' capacity to carry on their present high load.

The significance of data on patient load for the evaluation of the amount of medical care available to the population is borne out by the comparisons made in this paper. On the basis of the physician-population ratio, which rose from 838 persons per physician in September 1942 to 1,038 at present, it could have been assumed that the population was now receiving a smaller amount of medical care.

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REPORT ON HEALTH SECURITY ADMINISTRATION*

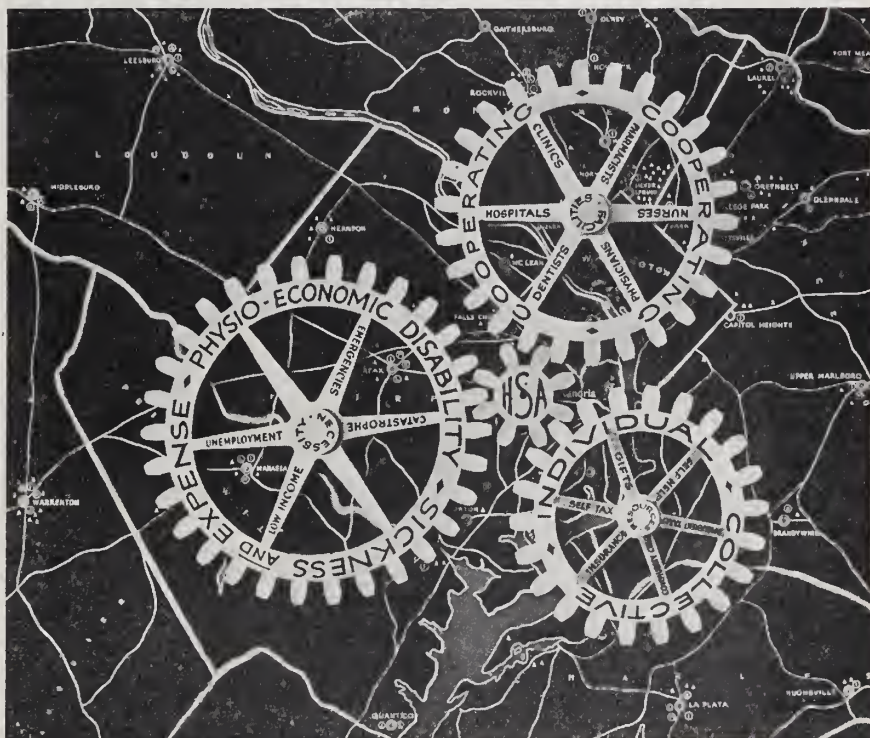
EDITOR'S NOTE: Our readers should find much of interest in this report. Too few physicians are aware that Health Security Administration owes its existence in no small degree to the Medical Society of the District of Columbia, which was one of its organizers. Unfortunately, the Society membership's interest in its offspring has lagged in recent years. It is to be hoped that this report will serve in some small measure to make them aware of the Administration's service to the community, the hospitals and the medical profession.

Due to the lack of space, portions of the report of no special interest to physicians have been deleted.

We Americans have long been known for our responsiveness to slogans. "Less government in business and more business in government" is one which to many of us seems to have been more honored in the breach than in the observance.

It has been the purpose of Health Security Administration to take seriously the need for more business in social work. The particular aspect of social work which concerns us is the provision of hospital and medical care for those in need but unable to arrange or pay for it without assistance. Financial assistance is derived from funds contributed through community chests, and recently through the Community War Fund, which are allocated to a hospitalization fund. This organization, in arranging care for patients, has always encouraged the patients, or parties responsible, to pay from their own resources to the extent of their ability without impairing their economic status to the point where they would require financial subsidy from some other social agency in obtaining food, shelter or clothing. His need for hospital care, nor his length of stay, cannot always be predicted by the

*From the Report to the Membership of Health Security Administration on January 30, 1945, by the Administrator, Willard C. Smith.



"GEARED FOR SERVICE"

Shown here is the manner in which Health Security Administration coordinates financial resources with health facilities to help persons with little or no income who are overwhelmed by sickness and expense, both occurring at the same time. The "wheels" really turn! Powered by a small motor the model was exhibited during the Community War Fund Campaign.

patient himself. The length of stay cannot even be predicted in all cases by the physician. The total cost of hospitalization, therefore, cannot be known in advance. Hospitals cannot however turn from their doors a human being in dire need of care simply because there is no money in sight at the moment to pay for the service required. Hospital bills usually fall upon the individual in moderate circumstances as a particularly heavy burden. "This is natural, for a hospital experience is a combination of a severe physical shock, a high emotional

crisis and a large economic expenditure. In the mind of the patient, there is no such thing as a small hospital bill although evidence is clear that a patient receives his money's worth in the typical well-run American hospital." (Rorem)

The hospitals of this metropolitan community may be obsolete in some cases but they are not as inferior as the public is sometimes led to believe by the reports of inquisitorial committees. We hear much, however, of the chaotic situation with respect to hospitals and hospital care in our community. Every hospital and health agency in the city, both public and private, would undoubtedly benefit from a comprehensive survey seriously and earnestly backed by responsible public opinion. This organization would welcome an analysis of its own operations by a competent outside surveyor. We are not afraid to learn how to do our community job better.

HOW THE ADMINISTRATION FUNCTIONS

Health Security Administration opened its doors and began functioning exactly ten years ago this month. Since last April 1, it has been functioning under an agreement developed by a joint committee of its own trustees, representatives of the Washington Community Chest, and representatives of the hospitals appointed by the Hospital Presidents' Association. This agreement has not changed our methods of arranging hospital and clinic care. We have always done that on the basis of accepted medical-social case procedures. Ours is simply a system for arranging care for those who need it, with the coöperation of the hospitals, and for providing payment at agreed-upon rates by using the Community Chest and other contributed funds, together with the collections from the patients themselves. Briefly, it can be described as follows.

Health Security Administration is a non-profit corporation, not a member of any community chest nor of the War Fund, whose membership includes equal representation from hospitals, medical professions, and the public-at-large, this latter group being primarily representatives of fund-raising agencies. Our purpose is to arrange hospital and medical care for persons who at the time of physical need are unable to pay for needed care as private patients. This function is exercised with a view to

minimizing the loss which all hospitals sustain on the charity work which they are obliged to do, to assure the physicians against undue exploitation of their free services, and to conserve and make the most effective use of funds contributed or allocated for hospitalization.

On the basis of medical-social case interviews, patients are asked to pay such portion of the reduced or concession rates agreed to by hospitals as they can afford to pay without disruption of the socio-economic status of their families. Their payments are made in small installments over indefinite but relatively long periods of time, the hospitals being paid monthly by cash advances from the total funds available. The total funds available are derived from two sources: (1) contributed funds, i.e., mostly community chests (and thus indirectly the Community War Fund), and (2) patient payments collected by HSA.

Since the funds available from these two sources are pooled, the operating costs of HSA may be thought of as taken from either source. In actual practice, the second source being more than sufficient and being available in the collections at HSA, the operating costs are paid out of this account, the organization's expenses being carefully checked and controlled by a budget committee of nine which, like the Board of HSA, includes equal representation from hospitals, medical profession and public-at-large.

PATIENTS' ACCOUNTS BUDGETED

There are three types of patient accounts:

1. The regular HSA account is that of a patient who is unable to pay more than the agreed-upon rates. Such a patient's hospital bill is paid on the monthly claim.

2. A budget extra account is one set up for a patient who is found to be able to pay the full amount of the agreed-upon rate for inpatient service and is probably able to pay also the hospital's charge for operating room, routine laboratory and other so-called "extras," but could not possibly pay any physician's fee. In such a case, the patient has two separate accounts at HSA: (a) for the total amount of the hospital charge at the agreed-upon rate for the length of stay estimated on the basis of medical opinion, and (b) for the amount of the hospital

"extras" plus the difference, if any, between the agreed-upon rate and the hospital's established per diem rate for ward-pay patients. All of the patient's payments are credited to the first of these accounts until it is paid in full. Succeeding payments are credited to the second account. Obviously the amount of the hospital's charges for "extras" is not known at the time arrangements are made for the patient's admission and can be known only after the patient is discharged. The amount of the first account is paid in full to the hospital on the regular monthly claim at the end of the month in which the patient is discharged, using both chest and HSA funds; whereas, the second account is payable to the hospital only on the basis of if, as, and when the patient pays HSA.

3. The third type of account is what we call a straight budget account. Such a patient is expected to pay the regular rate established by the hospitals including all of the extras for the service which he obtains. It may also have combined with it a budget account for the physician's fee. These accounts are set up only if the hospital itself and the physician elects to accept them. Payments on these accounts are not made on the monthly claims but only if, as, and when the patient pays. On this type of account we do not in the absence of results continue the collection effort beyond the statute of limitations, so that if we find it necessary to turn the account back to the hospital it can legally invoke the lien law. Straight budget accounts are of advantage both to hospitals and physicians. They represent an effort on the part of HSA to keep the patient on a self-sustaining basis, able to pay his own hospital and doctor bill in full, although he is



WAITING TO TALK WITH THE MEDICAL SOCIAL COUNSELORS

... at Health Security Administration. Arrangements are made with hospitals and clinics for outpatient and inpatient care. HSA certifies their eligibility to receive financial aid, and partial payments by patients supplement the Hospitalization Funds from Community Chests and other sources. Through the counseling service, many persons are shown how they can pay both doctor and hospital from their own resources. Such cases are "rejected" to private care.

unable to do so unless given an opportunity to make installment payments over a period of time. To be sure, both hospital and doctor could make direct arrangements or the bill could be placed in the hands of a commercial agency. HSA straight budgets, however, are intended for patients who are so near the borderline of need for assistance that their financial stability would easily be upset by an interest charge or a subsequent illness in the same family. In other words, such accounts are intended for persons who would be a bad risk and, as indicated above, they are resorted to only with the approval of the hospital or physician.

All HSA accounts which appear after the application of ordinary collection procedures to be uncollectible and on which no payment has been received for a period of sixty days are referred to the Division of Reviews and Adjustments. This division has been notably successful in reviving many accounts either by establishing contacts with other members of the family or by tracing the party responsible

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War Section

WASHINGTON MEDICAL OFFICERS PRESENTED CITATIONS

Lt. Colonel Walter R. Stokes, Air Corps, who is stationed at Camp Luna, Las Vegas, New Mexico, recently accepted a Meritorious Service Unit Award for his unit, according to the camp's newspaper, *Luna Glow*. "The Meritorious Service Unit Plaque, awarded by Maj. General Harold L. George, commanding general of the ATC," the *Glow* states, "was presented to the Camp Luna Weapons Section on April 2, at a simple but impressive ceremony held in the Post Exchange Auditorium. Colonel Harry



LT. COL. WALTER STOKES

S. Berry, commanding officer of Camp Luna, made the award to Lt. Colonel Walter R. Stokes, director of training and operations, who received the plaque for the commended organization.

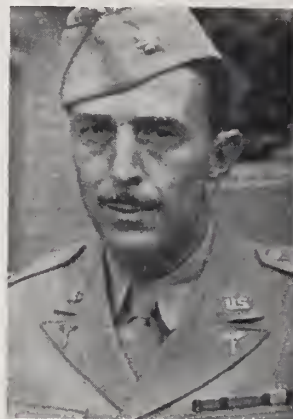
"The Meritorious Service Unit Award was earned by the Weapons Section, in the words of the citation, 'for its superior performance of duty and out-

standing devotion to the accomplishment of its assigned mission . . . achieving a high degree of military efficiency . . . superior individual conduct of its personnel, a high esprit de corps, a superior over-all technical and administrative record, and an outstanding level of discipline and morale.'

"The citation concluded by stating that 'in qualifying approximately 98 per cent of the enlisted men in the firing of firearms, the Weapons Section has made a valuable contribution not only to the 504th and 505th AAF Base Units but to the ATC as a whole.' "

Lt. Colonel Samuel R. Taggart, Medical Corps, Headquarters, 329th Medical Battalion, United

States Army, has, by the direction of the President of the United States, been awarded the Bronze Star Medal "for meritorious service in connection with military operations in Belgium, Holland, and Germany from 23 October 1944 to 11 March 1945. During this period of combat with the enemy, Colonel Taggart exhibited superior leadership, foresight, initiative and superb devotion to duty in the performance of his duties as medical battalion commander. The extremely low record of deaths in Division medical installations is exemplary of his untiring efforts to administer medical care to the wounded at the earliest possible moment despite all handicaps, and his actions, above and beyond the call of duty, reflect the greatest credit on himself and the military service."



LT. COL. S. ROSS TAGGART

Captain Robert L. Simpson, Medical Corps, 807th Medical Air Evacuation Sq., has been awarded the



CAPT. ROBERT L. SIMPSON

Bronze Star "for meritorious service in connection with combat operations in the Mediterranean Theater of Operations between 22 August 1944 and 23 October 1944. Captain Simpson's proficiency and devotion to duty reflect great credit upon himself and the Military Service of the United States."

Commander Oscar H. Fulcher, Medical Corps, United States Naval Reserves, now stationed at the U. S. Naval Hospital, Oakland, California, where he is Head of the Department of Surgery of the Central Nervous System, has just been presented a citation by Admiral Chester W. Nimitz, Commander-in-Chief of the U. S. Pacific Fleet, for "distinguishing himself by meritorious conduct in the performance of his duties as Neuro-Surgeon on the staff of a fleet hospital in the South Pacific area from April 4, 1943 to December 8, 1944. During this period, Commander Fulcher displayed excep-

tional ability in handling the many neuro-surgical cases received as a result of our operations against the enemy in the Solomon Islands and Central Pacific Campaigns. Through his untiring efforts and thorough knowledge of surgery, he contributed to the saving of many lives and alleviated the sufferings of many men. His professional skill was in keeping with the highest traditions of the naval service."

Commander Fulcher is authorized to wear the Commendation Ribbon.

LETTERS FROM MEMBERS IN THE SERVICES

From Lt. Colonel Alfred Brigulio, c/o Postmaster, New York, N. Y.:

Dear Ted: Since my last letter to you, we have been committed to action and were involved in the medical chain at the crossing of the Roer and its subsequent battles. I must say that we were very happy to have been included in the campaign. It was a most interesting experience and a little trying at times. Presently we're located in Germany in rather comfortable quarters. Over here, comfort implies a halfway decent place to live in, with some warmth. We trust to be able to go on and finish the job here in the near future. Here's hoping anyway!

From Captain Peter P. Brue, c/o Postmaster, New York, N. Y.:

Dear Ted: I have just received your dispatch containing a ballot for the election of officers for the ensuing year and the bulletin issued by the Committee on Medical Care of The Medical Society of the District of Columbia. I feel somewhat honored to be remembered enough to get these items. Of course, you know that a large number of us in the services are beginning to think of the time we will be back home picking up where we left off. We no doubt realize that it may not be the same. In our spare moments we think about what it will be like. Will it be socialized medicine? Will it be similar to the panel system here in England? . . . Will it be "Stare's Cut-rate Clinic"? Or will it be a mixed affair with no rhyme or reason? I often wonder what the answer is going to be.

Here in England they have the panel system. During the past year there has been a great deal of discussion as to state control. I happened to read an article in the *Daily Mirror* of the 28th of March. In this article by Bill Greig it appears that the Government has decided to leave hands off and let the medical profession solve the problem. I am enclosing this article for you to read and use as you see fit. There may be many other articles that I have never read as I do not always get a chance to read the newspapers.

Recently a medical officer was assigned to this depot who went to school in Glasgow. He is a native of Brooklyn, N.Y.,

and has been in the U.K. since 1936. He has seen a lot of British medicine. This month will be his twelfth in the Army. He states that from what he has seen in the Army, even though it is good medical care for troops, he would prefer to practice here than to go back to the States and practice as we do in the Army or under socialized medicine. . . In many instances I feel like he does and I often find myself promising myself to go into farming or landscape gardening, or some other such job rather than to practice under government or lay control. Perhaps it is the fact that I have been away from private practice for three years that makes me feel so radical, but the feeling persists. Then I read the enclosed article and I decided to write to you.

It seems to me that the only way to give medical care to the class that needs it the most and seeks it the least, i.e., the lower middle class, which is too proud to seek charity and too poor to use private or usual medical care, is to have one large clinic made up of all the doctors and hospitals which still gives the patient the doctor-patient relationship and the hospital nearest his home. This might be run by the Medical Society or a separate set-up. Members could be recruited by publicizing. Membership might cost either 10 or 15 per cent of the yearly wage. I pick that percentage because I think 40 to 50 per cent of the yearly wage should be used for rent, food and clothing, 10 or 15 per cent for medical care, and the rest for higher education, recreation and savings. Medical care is like taxes, eventually everyone needs some. Therefore, I say 15 per cent of the yearly salary for medical care. Besides, most doctors are in the habit of charging patients according to their ability to pay. Why couldn't the percentage basis be used somewhat along the same lines as the Officers' Club dues in the Army?

This is all just a thought on my part. I can't for the life of me think of any other method but I might stumble upon something sooner or later. I shall be anxiously waiting for the next bulletin from the Committee.

As for me here, I am back as Battalion Surgeon with the 52nd Reinforcement Battalion. I believe G. F. R. C. has done a wonderful job of weeding out the non-combat material and sending to the front trained infantrymen. It gives me

a funny feeling to have some G.I. come up to the dispensary and ask me if I wasn't the doctor who processed him before D day. So you see I meet them going and coming. This work is nerve-wracking as the percentage of men who try to develop some nondescript ailment runs fairly high. That is human. Still, it is a hard job to separate the sincere ones some of the time. This depot is retraining men as riflemen. We had a parade in honor of our late President, Mr. Roosevelt. It was a grand spectacle.

I miss the cherry blossoms, the heat and the hustle-bustle of Washington. My longing for the place grows every minute. I hope that one of these mornings I wake and hear the good news that hostilities have ceased. . .

Before I close, let me tell you a poem, the body of which I thought rather cute.

There once was a lady named Gaul
Who wore a newspaper dress to a ball;
Her dress caught on fire,
And burned her entire
Front page, Sports section, and all!

From Major Robert H. Detwiler, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: Thought that I would drop you a line to give you my new APO and thereby speed up the delivery of my *Medical Annals*. I enjoy receiving the journal and find it interesting reading, particularly when so much of the usual medical literature is missing from our lives here.

I have also enjoyed your letters and appreciated all the newsy items. Lately I have seen several Georgetown graduates, but none from D. C. Here in the forward area doctors seem scarce but the scarcity keeps me busy and therefore fairly happy.

From the progress of the war on this front (including Burma) we have hopes of getting the job done before the monsoons set in. Possibly we may be able to move to a new country and miss the very bad weather entirely. Flying over here is pretty rough in good weather and we frequently get lost coming home after winding in and out the mountains. What it will be like when we go entirely on instruments, I will soon find out.

Remember me to my friends in the Society and let us all hope that we will be able to get together in a couple of years and settle down for good.

From Lt. Colonel Edward J. Grass, c/o Postmaster, San Francisco, Calif.:

Dear Professor: Hello Ted. It's been some time since you heard from me. I was in on one of the big landings in the Philippines which accounts for the delay. Your letter of January 29 just arrived and I would say with the exception of letters from my wife, I can't get the envelope open fast enough to read the contents.

When I received your letter I was deep in "A Tree Grows in Brooklyn," but discarded this book and reread your letter six times. Thanks many times and the news you give us I consider one of the highlights of our Army careers.

I am O.K. and you will be hearing from me shortly again.

From Captain James M. Loftus, c/o Postmaster, San Francisco, Calif.:

Dear Mr. Wiprud: I am in receipt of your letter of January 29th and was very glad to hear from you and Washington. One certainly loses contact with home after 18 months overseas.

I am enjoying my present home after a year on a desolate isle in the South Pacific. I am near a city that the Japs wrecked in their anger at their inability to defend it successfully.

The native people were very happy to receive us and although they do not have very much of the world's goods, they have a cheerful and pleasant smile. The Japs confiscated their food and I have had the opportunity of seeing some advanced cases of vitamin deficiency diseases.

I am the surgeon for a combat engineer battalion—a tough, efficient outfit. We recently made an amphibious landing and it was just like those you have seen in the movies. I enjoy my work and try to accept things as they come. It is all in a day's work to tell a patient to wait until the bombs stop falling so you can hear his heart sounds. I have met quite a few Washington physicians out here.

Everyone likes to see night out here as it means one day nearer to home.

From 1st Lieutenant Bernard E. Nunez, c/o Postmaster, San Francisco, Calif.:

My dear Mr. Wiprud: I received your welcome letter out here on this faraway island. I was disappointed that you did not include some of your usual gossip for I am completely out of touch with the "friends" of the medical profession at home. I have not received one letter yet from them. I guess they are "too busy." We are not exactly loafing out here.

We landed on this island on April Fool's Day. I think our sense of humor is terrific for we certainly fooled the Japs. There is no use telling you about the war because the newspapers, I am sure, can do that better than I can. I will say that war is terrible, tragic and rather dull. Newspapers glamorize war too much. It is a brutal existence, especially for the infantryman—the real hero of this war as far as I am concerned. They fight for days and nights on end, come back all beaten up, but you don't hear a word of discouragement. It is truly amazing. We can all feel proud of the American doughboy.

I am Division Malariologist and Epidemic Disease Officer for the 96th Infantry Division and as such get a chance to go around on a lot of trips in the good old "jeep." I have examined many civilians to ascertain the disease situation here, made malaria surveys, etc. I don't think the medical situation will be as bad as I had pictured it. The people are docile, and wonderful farmers. The women wear zoot-suit slacks and look very unusual and picturesque. The children are children and do not realize what it is all about. They are having a grand time.

In my spare time, I am in charge of the shock and pre-operative tent here at the clearing station. We worked for

(Continued on page 238)

On The Home Front

Permanent Pharmacopoeial headquarters were authorized by the Board of Trustees at the 1940 Pharmacopoeial Convention, with Washington, D.C. referred to as a desirable location. Because wartime conditions make Washington wholly impracticable for the purpose at this time, temporary headquarters are now being provided at 4738 Kingsessing Avenue in Philadelphia. The new offices will be located within a few squares of the Philadelphia College of Pharmacy and Science, which has generously provided quarters for the Pharmacopoeial Revision Chairman and his staff for almost twenty years.

The Board of Examiners of the American College of Chest Physicians announces that the next written examination for Fellowship will be held at Chicago, June 16. Candidates for Fellowship in the College who plan on taking the examination should write the Executive Secretary of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The Modern Hospital Publishing Company announces competitive awards of \$500, \$350 and \$150 for an essay on the subject, "A Plan for Improving Hospital Treatment of Psychiatric Patients." Judges in the contest will be drawn from the U. S. Public Health Service, the American Psychiatric Association and the National Committee for Mental Hygiene. Hospital administrators, psychiatrists, psychologists, social workers, nurses, therapists, former patients and any other interested persons are eligible to compete. The manuscript, not to exceed 5,000 words in length, should be mailed to the Managing Editor of Modern Hospital, 919 North Michigan Avenue, Chicago 11, Illinois, in time to reach that address by October 1. Winners will be announced on or before December 31.

The Section on Pediatrics met April 19 in the Society's Library. Drs. Frederic G. Burke and Sydney Ross of Children's Hospital presented a

CALENDAR OF MEETINGS

April 5	Subcommittee on Venereal Disease Section on Neurology and Psychiatry
April 9	First Lecture, Postgraduate Course in Physical Medicine
April 10	Grievance Committee
April 11	Scientific Meeting of Society
April 13	Board of Censors
April 16	Second Lecture, Postgraduate Course in Physical Medicine
April 18	Program honoring General Ireland
April 19	Medical Bureau Committee Section on Pediatrics
April 20	Subcommittee on Survey, Procurement and Assignment Committee Membership Committee
April 23	Third Lecture, Postgraduate Course in Physical Medicine
April 24	Committee on Public Health
April 30	Executive Board

"Preliminary Report on Oral Administration of Penicillin."

The Washington-Baltimore Psychoanalytic Society held an open meeting, April 14, at Hurd Hall, Johns Hopkins Hospital, Baltimore. Lt. Colonel Henry W. Brosin, Neuropsychiatric Consultant to the Third Service Command, discussed "Some Problems of the Returning Servicemen."

Major General Merritte W. Ireland, Medical Corps, U. S. Army, Retired, Surgeon General of the U. S. Army 1918-1931, was honored by the Medical Society on April 18. He was presented with a citation for "distinguished service to humanity and his outstanding contributions to military medicine."

A complete report on this noteworthy event will appear in the June issue of the MEDICAL ANNALS.

At its meeting, March 26, the **Executive Board** voted to recommend to the Society that **Dr. Henry C. Macatee** and **Dr. William P. Herbst** be named delegates to the Council of Social Agencies. The Board approved the appointment of **Dr. William C. Woodward** as a member of the Committee on Public Policy.

The **Georgetown Clinical Society** presented its first "G" award for "distinguished service" in the practice of medicine or surgery to **Commander Joseph J. Mundell, M.C., U.S.N.R.**, April 19, at a dinner meeting at the Statler Hotel. Dr. Philip A. Caulfield, President of the Society, presided. The occasion marked the inauguration of an annual award, in the form of a "G" plaque and an inscribed certificate, to be made to a Georgetown alumnus who particularly distinguishes himself in private practice and in service to the School of Medicine.



COMDR. JOSEPH J. MUNDELL

Dr. Mundell graduated from Georgetown University School of Medicine in 1903 and has been engaged in the practice of medicine in the District of Columbia for 39 years. For the past 11 years he has been Professor of Obstetrics and Director of the Department of Obstetrics at Georgetown University. He is a diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American College of Surgeons, and was one of the founders of the Georgetown Clinical Society in 1906.

During World War I Dr. Mundell served at the Naval Dispensary, holding a commission as Lieutenant. Since that time he has served in the U. S. Naval Reserves as consultant in obstetrics and gynecology, retaining his office at the Dispensary.

George Washington University Medical Society devoted its meeting, April 21, to the subject of penicillin therapy. The following aspects of this topic were presented: "Indications and Limitations,"

Dr. Harry F. Dowling; "Methods of Administration and Dosage," Lt. B. F. Eckardt of the U. S. Naval Hospital; "Venereal Diseases with Special Reference to Treatment," Comdr. G. J. Thompson of the U. S. Naval Hospital; and "Present and Future Possibilities—Office and Home Use," Dr. Paul F. Dickens.

The **Clinico-Pathological Society** met April 3 at the Kennedy-Warren Apartments; Dr. Lewis Ecker was host. Two papers were presented: "Some Thoughts on War Ophthalmology," by Colonel Derrick T. Vail, Chief Consultant in Ophthalmology, Surgical Consultants Division, and "Penicillin in Chronic Mastoid Infections," by Dr. William H. Jenkins.

Alpha Epsilon Iota, national women's medical organization, sponsored a showing of the motion picture, "That Others Will Live," April 12, at George Washington University School of Medicine. The picture was made by Drs. Charles Stanley White, J. Lloyd Collins and J. J. Weinstein. Dr. Weinstein also gave a talk on the history and development of plasma.

Under the sponsorship of the **District Tuberculosis Association**, the **Medico-Chirurgical Society of Washington, Inc.**, the **Social Hygiene Society** and **Howard University School of Medicine**, a five-day seminar for practicing colored physicians was held April 16-20 at Howard University. Speakers discussed the prevention and treatment of tuberculosis, syphilis, rheumatic fever and poliomyelitis. Among members of the District Medical Society who appeared on the program were Dr. Walter K. Myers, Dr. John L. Parks and Dr. Herman E. Hilleboe.

Dr. Daniel L. Borden has resigned from the chairmanship of the District Board of Police and Fire Surgeons, effective April 16. Dr. Borden has been on leave from the Board since 1941, when he entered military service.

The **District Tuberculosis Association** sponsored a panel discussion, April 30, on "The Problems in the Control of Tuberculosis in the District" in the auditorium of the U. S. Chamber of Commerce. Dr. George C. Ruhland and Dr. Herman E. Hilleboe

were the principal speakers. Among those who participated in the discussion period was Dr. Clayton B. Ethridge.

Dr. Fred O. Coe was the guest speaker at a meeting of the District Society of X-ray Technicians, April 5.

Dr. Emil J. C. Hildenbrand visited the Massachusetts General Hospital and the Lahey Clinic in Boston in February for the purpose of observing surgical procedures in hypertension.

Deaconess Anna E. Macdonald resigned as Superintendent of **Episcopal Eye, Ear and Throat Hospital**, April 1, after 17 years' service at the Hospital. She had served the Hospital as Superintendent of Nurses, Acting Superintendent and for a number of years as Superintendent. **Deaconess Margaret E. Bateman**, Superintendent of Nurses, resigned her position also and both have accepted positions on the staff of the Children's Educational Foundation at Seattle, Washington.

Mr. Arthur B. Solon, Superintendent of Mt. Vernon Hospital, Mt. Vernon, N. Y., arrived in Washington April 16 to become Superintendent of **Suburban Hospital**, Bethesda, Md. He will succeed **Mr. J. Dewey Lutes**, who left April 1 to assume the superintendency of the Yonkers General Hospital, Yonkers, N. Y.

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review. After the reviews have been published the books will be placed in the New Book Section in the Medical Society's Library. There they may be examined at leisure but cannot be removed from the building.

"Doctors at War," edited by **MORRIS FISHBEIN, M.D.**, Editor of the Journal of the American Medical Association and of *Hygeia*, The Health Magazine; Chief Editor of War Medicine; Chairman of the Committee on Information of the Division of Medical Sciences of the National Research Council. Price, \$5.00. Pp. 418, illustrated with photographs and charts. New York: Dutton, 1945.

Yellow Magic—The Story of Penicillin. J. D. RATCLIFF. Price, \$2.00. Pp. 173. New York: Random House, 1945.

BOOK REVIEWS

Poet Physicians, An Anthology of Medical Poetry Written by Physicians, compiled by **MARY LOU McDONOUGH**. Price, \$5.00. Pp. 211. Springfield, Ill.: Thomas, 1945.

Mrs. McDonough has worked long and earnestly to compile an anthology which will interest those, especially physicians, who like poetry. No less than 110 poets are represented, all of them physicians. The cumulative index provided in the volume lists about 350. Not all of the poems deal with medical topics, although most of them do. As one would expect, most of the poets are American, Canadian or British—that is as it should be, for poetry nearly always suffers by translation from a foreign tongue—but we find representatives of Mexico, Italy, France, Germany, Japan and China.

Some of the names are far more familiar to us in other roles than as physicians—Crabbe, Goldsmith, Keats, Schiller and Smollett—while others rank high in the field of medicine, as Sherrington and Head, McCrae, da Costa and Jenner.

As we might expect from physicians, many of the verses treat of birth and death, disease, dissections, the hospital, melancholia, and so on. Some are familiar, many are not; some are high poetry, some are hardly more than jingles. Washington is represented by three names, Ambassador Castillo-Najera of Mexico, our own Dr. Walter Freeman, and the late Dr. Fielding Garrison.

Dr. Merrill Moore, the extraordinarily prolific sonneteer, contributes (in prose) a Memorandum on Medical Poets. "By and large," he says, "the medical poet is not quite so poetic a poet and not quite so successful a poet as the general poet is." Whether this statement be correct or not, Mrs. McDonough has accomplished a useful and competent piece of work. The format, as we always expect in Thomas' books, is excellent.

W. O.

Fertility in Women—Causes, Diagnosis and Treatment of Impaired Fertility. **SAMUEL L. SIEGLER, M.D.**, F.A.C.S., Attending Obstetrician and Gynecologist, Brooklyn Women's Hospital; Attending Gynecologist, Unity Hospital; Assistant Obstetrician and Gynecologist, Greenpoint Hospital; Attending, Sterility Clinic, Greenpoint Hospital; Consultant in Gynecology, Rockaway Beach Hospital; Diplomate, American Board of Obstetrics and Gynecology; Fellow, New York Academy of Medicine; Member, Society for the Study of Internal Secretions. Price, \$4.50. Pp. 450, with 194 illustrations. Philadelphia: Lippincott, 1944.

Fertility in Men. A Clinical Study of the Causes, Diagnosis, and Treatment of Impaired Fertility in Men.

ROBERT SHERMAN HOTCHKISS, B.S., M.D., Lieutenant Commander (M.C.) U.S.N.R., (on active service); Assistant Professor of Urology, New York University Medical College; Instructor in Surgery (Urology), Cornell Medical College; Assistant Visiting Attending, Department of Urology, Bellevue Hospital; Assistant Visiting Attending in Surgery (Urology), New York Hospital; Chief of Urological Clinic, New York University Medical College Clinic. Price, \$3.50. Pp. 216, with 95 illustrations. Philadelphia: Lippincott, 1944.

These two companion volumes present in an orderly fashion the rather complex subject of human fertility, particularly from the clinical approach.

Siegler's book is replete with detail, so much so, in fact, that the reader is at times unable to see the forest for the trees. After an introductory chapter on the problem of human fertility with some historical background, a general chapter on methods of evaluating fertility is presented. The author presents his own plan of investigation which is most complete indeed. The general practitioner, who handles most of the clinical sterility problems, might become rather discouraged at such an awesome evaluation.

There follow chapters on history taking and the physical examination. The latter is illustrated with many extraneous pictures of extreme endocrine disorders. It contains an excellent section on factors influencing successful impregnation. The physiology of the female sex cycle (whatever that is) is next discussed with clarity and great detail. Especially well presented is the section on ovulation and methods of determining it. In logical order the sixth chapter discusses the cervical and vaginal secretions, with particular emphasis on the postcoital examinations. The next chapter deals with tubal factors and their evaluation by various means and is especially valuable.

In succession, there follow three chapters on treatment. The first is concerned with general treatment and is carefully and adequately outlined. In particular, the warning against meddlesome surgery, even the seemingly innocuous dilatation and curettage, is important. The second chapter deals with the treatment of ovarian imbalance by means of endocrine therapy, surgery, and irradiation. The third chapter on treatment deals with the management of faulty reception of spermatozoa. The many therapeutic agents which have been advocated are evaluated adequately and clearly. The presentation of the data is excellent. The portion on artificial insemination is well done.

The final chapter is concerned with the problem of abortion. This is clearly presented. The possible role of the husband is emphasized both from the angle of poor gametogenesis as well as the Rh factor. Under

treatment, the generally accepted therapeutic agents are presented.

All in all, the reviewer feels that "Fertility in Women" by Siegler is a book mainly for the specialist in this field. The average general practitioner would soon be lost in the maze of details.

Turning to "Fertility in Men" by Hotchkiss, we find a clear, concise presentation. The opening chapter deals with general considerations. The second chapter correlates clearly the relationship of structure to function in outlining the anatomy and physiology, normal and abnormal, of the male genital organs. The third chapter on the metabolism of spermatozoa and the chemical composition of the semen is based, in the main, on the excellent work of MacLeod, a colleague of the author. The great amount of detail, however, serves to detract from the fundamental significance of the data. The fourth chapter is concerned with methods of appraising fertility of men. This covers the history, general and sexual, and the physical examination, general and genital.

The next four chapters cover laboratory tests in general, and, in great particular, those of semen analysis. It is only by careful evaluation of the semen and particularly the spermatozoa that progress will ever be made in the solution of the multifaceted problems of fertility in men.

The final chapter (9) deals with treatment. In order, the following subjects are taken up: volume, turbidity, viscosity, motility, cell count and morphology. Therapeutic procedures directed to abnormalities of the above are succinctly presented with appropriate case histories. The importance of general supportive measures is emphasized. The great value of prostatic and seminal vesicular massage for an unfavorable prostatic-seminal vesicular medium is clearly evident. The tremendously important procedure of testicular biopsy is very distinctly brought out when it becomes necessary to know whether or not spermatozoa are being produced and in proper number in the seminiferous tubules. The value of surgical measures for obstructive azoöspemia is well presented.

In summary, "Fertility in Men" by Hotchkiss is a book that can be recommended very highly indeed not only to the urologist but also to the general practitioner.

A. R. A.

Psychiatry in Brazil—Carmago

(Continued from page 198)

legal functioning of such institutions, and they are being invited to fulfill the requisites for their class of institution.

After the War there will be held in Rio de

Janeiro the third International Congress on Mental Hygiene. The first was held in the United States in 1930; the second in Paris in 1937. Brazil was chosen to be the seat of the third Congress, fixed for 1940. Unfortunately the Congress had to be put off until after the War. We hope to be able to bring together on that occasion the greatest possible number of psychiatrists from the United States, and the Brazilian Mental Hygiene League has already established contact with Dr. George Stevenson, Medical Director of the National Committee for Mental Hygiene, who will very likely be the head of the delegation from this country. Brazil has asked for his suggestions and his valuable collaboration in organizing the official subjects to be discussed.

Brazilian psychiatry, as you have seen, is still a bit young, but it is full of enthusiasm and desirous of full development. Contact with American psychiatry, so flourishing and adorned with triumphs achieved on the long road of research and clinical and administrative work, can bring us only good. It is incontestable that this country possesses today the best psychiatric services in the world. I should like Brazilian and American psychiatrists to know each other better. There should be a permanent and more frequent interchange of ideas, so that there would be a homogeneity in our culture and professional progress. This would be of great value to the progress of the American Hemisphere, since the two peoples are so intimately united by ties of indestructible and traditional friendship.

Penicillin for Gonorrhea—Creswell and Putnam

(Continued from page 205)

200,000 units of penicillin. The site of choice for the injections is the large muscles of the outer, upper quadrant of the buttocks. The smaller quantity of fluid (2 c.c.) causes little or no pain.

Since the introduction of penicillin the management of gonorrhea has changed materially. This changed condition will make gonorrhea a medical curiosity in the near future.

Sternal Transfusions—Dardinski

(Continued from page 206)

edge of the sternum as well as great dexterity and temerity. In case of doubt, it is safer for the patient to expose a vein by surgical technic in order that the blood may be more readily administered.

Watchful waiting and hopeful anticipation in cases of erythroblastosis are not to be recommended, especially when there are marked jaundice and anemia.

Transfusions of Rh negative blood must be given when there is a rapid drop in the total number of red blood cells, if good results are to be obtained. I therefore recommend a frequent check of the red blood cell count in order to determine the progress of the patient.

Survey of Practicing Physicians—Ciocco and Altman

(Continued from page 226)

Actually, due to greater effort of the medical profession, as shown by the patient load data, the population is still receiving the same amount of care. It is doubtful whether the patient load can be increased much further, for it should be noted that the present increase has been mostly due to the increased burden assumed by physicians in the older age groups.

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Report on Health Security Administration

(Continued from page 229)

through several changes of employment, often finding that he is earning more money and has greater paying ability than at the time the account was first set up.

PHYSICIANS NOT IMPOSED UPON

On regular HSA accounts and on budget extra accounts, no physician's fee is contemplated. Neither the hospital nor HSA has a right to impose on the gift of a staff doctor's services. When HSA certifies a patient for inpatient care, the staff physicians may rest assured that the patient is really needy and is entitled to free medical care.

It would be a real service to their staff physicians if the hospitals would see to it that the charts of all house cases were stamped or otherwise clearly marked as entitled to free medical care. As a matter of fact, the HSA-Chest-Hospital agreement provides that hospitals may not, with certain exceptions, furnish hospitalization with free medical care on a part-payment or no-payment basis unless the patient has been certified by Health Security Administration.

CONCLUSION

Whenever I am asked to describe the functions and activities of HSA, I think of the dear old lady who asked her bookdealer for an unabridged copy of the Bible with full concordance of the scriptures, printed in large bold face type, and in vest-pocket size so that she could carry it in her purse and read it on the streetcar!

I could not on this occasion report the work of HSA as fully as I would like it to be understood. I have not felt that I should try to find ways and means of spending the full amount of our budget approved by the Budget Committee whether it was necessary or not. For three successive years I have turned back a portion of the approved budget unexpended. During the past year our rate of expenditures has been increased by circumstances over which neither I nor the Budget Committee had any control.

The chief item unexpended this year has been that for publicity. It is my judgment that the hospitals, the physicians who provide the service, the Community War Fund and all others concerned will really benefit from a wise expenditure of an

adequate amount for publicity. Continued economy to the point of spending nothing for this item may be responsible for the circumstances which make us feel sometimes that we are least understood by those whom we try most to serve.

War Section

(Continued from page 232)

five days and nights under some artillery fire but the doctors kept on operating. Under these trying circumstances, our results were wonderful. Whole blood flown from San Francisco was available at all times in my shock tent and I can tell you it was life-saving in more than one instance. The medical care out here in the field is excellent and we work with greater zeal than ever before. The medical profession should be justly proud of the surgeons out here in the field. They do major surgery under a tent with bullets flying over their heads and get wonderful results. There is not a man out here who has not had a Jap artillery shell land at least 50 feet away and sometimes too close to live.

Well, best regards from a lucky doctor who is looking forward to getting back home as soon as this is over.

From Lt. Commander Paul J. O'Donnell, c/o Fleet Postoffice, San Francisco, Calif.:

Dear Mr. Wiprud: Thanks for the ballot and the last news letter.

Was at Iwo Jima and everything you read about it is true. Don't know if any local M.D.'s were in on it. At least, I did not recognize any of them watching through glasses from D day until D + 9.

I understand Don Knowlton is out here and if so, we just left him. The place, as you know, is "Mum" until one month has passed.

Don't complain about the cold weather in D.C. Here it is hot as Hades.

From Commander Oscar H. Fulcher, U. S. Naval Hospital, Oakland, Calif.:

Dear Ted: I am very sorry that I did not get a chance to see you while I was in Washington during January. I had to rush back to the coast to begin the next tour of duty. I wanted to tell you how much I have enjoyed your delightful letters. I hope that I shall continue to receive them in the future.

I noticed a little error in the last issue of the *Annals*. I received my present commission quite some time ago; in fact, it is dated July, or rather, August 1, 1942. I accept the congratulations gladly, however.

I hope that I shall have a chance to see you before too long.

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THE FUTURE OF PHYSICAL MEDICINE*

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AT LAST the long delayed development of physical medicine seems to be at hand.

Physical medicine includes the employment of the physical and other effective properties of light, heat, cold, water, electricity, massage, manipulation, exercise and mechanical devices for physical and occupational therapy in the diagnosis or treatment of disease.

Physical medicine is applied biophysics. Dr. Alan Gregg, Medical Director of the Rockefeller Foundation, said recently: "Among my major hopes, let me record the wish that biophysics may be soon recognized as the brother of biochemistry, even if the time is now too late to consider it a twin.... One of the natural outgrowths of such a preclinical science might be the now long overdue development of physical therapy in this country."

Physical agents are employed not only for therapy but also for diagnosis; therefore the term "physical medicine," long in use in England, is gradually replacing the designation "physical therapy" in this country. Physical medicine is the more generic and more inclusive term and as defined herewith it embraces physical therapy,

occupational therapy and the employment of physical agents for diagnostic purposes.

Physical medicine has developed to a point at which it must be considered as a separate and distinct medical specialty. The recent tremendous interest in this special branch of medicine, culminating in the activities of the Baruch Committee on Physical Medicine, indicates that physical medicine has at last come of age.

Dr. Frank Ober, Assistant Dean of Harvard Medical School, told me recently: "The last war established orthopedic surgery as a recognized specialty. This war may well do the same for physical medicine." But the war is not the only factor responsible for the sudden maturing of physical medicine.

Since the pioneering days of Dr. Simon Baruch, the father of hydrotherapy in America, there has been a gradual unfolding of all phases of physical medicine until now it is beginning to burst into full scientific bloom.

This development is perhaps due to natural evolution. Dr. W. C. Davison, Dean of Duke University School of Medicine, has mentioned that medicine has gone through four periods: (1) a primitive period in which the employment of physical agents played an important role, (2) the Renaissance period, (3) the period of

* Second Lecture in the Postgraduate Course in Physical Medicine, sponsored by the Society, April 16, 1945.

pharmacy, and (4) the modern period during which we have emphasized successively prevention, pathology, bacteriology, biochemistry, surgery and specific therapy. Now we are back to nonspecific and physical therapy, which, Davison concluded, "demands increased study and greater use." We must treat the patient as well as the disease.

The Council on Physical Medicine of the American Medical Association and more recently the Committee on American Health Resorts have contributed largely toward the development of physical medicine.

Still more recently the National Foundation for Infantile Paralysis, on the advice of a distinguished group of scientists headed by Dr. Walter Cannon, has recognized the need for the advancement of physical medicine and provided the first large grant for establishment of a center for teaching and research in physical medicine at the University of Pennsylvania.

The National Research Council has recognized the need for more study of the employment of physical agents, particularly in the management of peripheral nerve injuries, and has made numerous grants for research in this field.

Finally, our famed elder statesman and humanitarian, Mr. Bernard M. Baruch, impressed with the possibilities of physical medicine by his father, the late Dr. Simon Baruch, appointed a committee headed by Dr. Ray Lyman Wilbur to make a survey and to report on the programs deemed best for adequate development of physical medicine in the United States.

This survey committee was composed of eight men: (1) Dr. Ray Lyman Wilbur, Stanford University, Stanford University, California, *Chairman*; (2) Dr. William T. Sanger, Medical College of Virginia, Richmond, Virginia, *Vice Chairman*; (3) Dr. Frank H. Krusen, Mayo Clinic, Rochester, Minnesota, *Director-Secretary*; (4) Captain Charles F. Behrens (MC), U.S.N., Bethesda, Maryland; (5) Dr. Carl R. Comstock, Saratoga Springs, New York; (6) Dr. John S.

Coulter, Northwestern University, Chicago, Illinois; (7) Dr. Kristian G. Hansson, Cornell University, New York, New York, and (8) Lt. Colonel Benjamin A. Strickland, Jr., (MC), U. S. A., Tucson, Arizona.

Eight subcommittees, composing a group of forty scientists, were appointed. These subcommittees dealt with the following phases of physical medicine: (1) teaching, (2) basic research, (3) clinical research, (4) public relations, (5) rehabilitation, (6) hydrology and health resorts, (7) occupational therapy, and (8) prevention and body mechanics.

The subcommittees, in turn, consulted directly more than 400 outstanding scientists concerning various phases of their problem.

The survey was begun on November 1, 1943, and the final meeting of the committee was completed on January 30, 1944.

NEEDS OF PHYSICAL MEDICINE

It is obvious that the chief needs for proper development of physical medicine are: (1) an adequate supply of physicians who can teach and use physical medicine, (2) more extensive basic and clinical research in physical medicine, and (3) proper use of physical medicine in relation to wartime rehabilitation and peacetime physical preparedness.

On completion of its survey the committee recommended the following immediate program for sound development of physical medicine on a lasting basis:

1. Organization of a central office, including: (a) a governing board and (b) an advisory board.

2. Establishment of teaching and research centers in physical medicine at interested medical schools. Under this heading the following specific recommendations were made:

- a. That one of the medical school teaching and research centers might become a model center in which all phases of physical medicine, including physical therapy, occupational therapy, electronics, hydrology, climatology, manipula-

tive procedures and physical rehabilitation, could be developed. (Columbia University College of Physicians and Surgeons has been given \$400,000 to establish this model center.)

b. That one of the research and teaching centers devote its major attention to the problems of hydrology, climatology and spa therapy. (The Medical College of Virginia has been given \$250,000 to establish this center.)

c. That one of the centers of physical medicine devote its major attention to the preventive and manipulative aspects of the structural mechanics of the human body. (New York University has been given \$250,000 to establish this center.)

d. That because of the increased importance of electronics and other physical agents, one of the centers of physical medicine promote the coördination of the work in research laboratories devoted to projects in physical medicine with the work in other research laboratories, commercial and academic, in the hope of furthering the development of electronic and other physical equipment which could be employed in research in, and clinical application to, physical medicine.

e. That one of the centers on physical medicine promote special clinical investigations of the psychologic and psychiatric aspects of physical medicine, with special reference to a study of the value of personal contact between physician and patient.

3. Establishment of fellowships and residencies in physical medicine. The committee recommends:

a. That support be given to the establishment of fellowships and residencies for interested young physicians, and other scientists, who can be trained in the teaching of such subjects as clinical physical medicine and basic research in physical medicine.

b. That the previously mentioned centers for physical medicine consider training such fellows in hydrology, climatology and spa therapy, as well as in electronics, physical rehabilitation and manipulative procedures, and that special attention be given to kindred sub-

jects, such as industrial medicine, treatment of the aged and treatment of rheumatic diseases, diseases of the blood vessels, and diseases of the nervous system. (The sum of \$100,000 has been set aside for provision of such fellowships.)

4. Promotion of teaching of, and research in, physical medicine in all approved medical schools. (The sum of \$100,000 has been set aside for support of these projects.)

5. Promotion of wartime and postwar physical rehabilitation. Because of the constantly increasing responsibility and the urgency required to meet the emergency conditions, it is recommended that prompt steps be taken for meetings of a special committee which will coördinate and correlate all matters pertaining to basic research and rehabilitation in Army, Navy and civilian life. [A committee on war and postwar physical rehabilitation and reconditioning has been established to coördinate these efforts. This committee has the following members: Lt. Colonel Walter E. Barton, (MC), A.U.S., Washington, D. C., Assistant Director of the Reconditioning Division and Chief of the Blind and Deafened Rehabilitation Branch, Office of the Surgeon General, War Department; Captain Charles F. Behrens, (MC), U.S.N., Bethesda, Maryland, Chief of the Radiological Service, Naval Medical Center; Dr. Dean A. Clark, Senior Surgeon (R), U.S.P.H.S., Washington, D. C., Chief Medical Officer, Office of Vocational Rehabilitation, Federal Security Agency; Dr. Charles M. Griffith, Washington, D. C., Medical Director, U. S. Veterans Administration; Captain Frederick A. Jostes, (MC), U.S.N.R., Washington, D. C., Office of Rehabilitation, Bureau of Medicine and Surgery, Navy Department; Captain Howard Montgomery, (MC), U.S.N., Washington, D. C., Chief of Rehabilitation, Bureau of Medicine and Surgery, Navy Department; Colonel Howard A. Rusk, (MC), A.U.S., Washington, D. C., Chief of Convalescent Division, Office of the Air Surgeon, War Department; Mr. H. V. Stirling, Washing-

ton, D. C., Director of the Vocational Rehabilitation Service, Veterans Administration; Lt. Colonel Benjamin A. Strickland, Jr., (MC), U. S. A., Tucson, Arizona, Commanding Officer, A.A.F. Regional Station Hospital, Davis-Monthan Field, Tucson, Arizona and formerly head of the Physical Therapy Department, Walter Reed General Hospital; Colonel Augustus Thorndike, (MC), A.U.S., Washington, D. C., Director, Reconditioning Division, Office of the Surgeon General, War Department and Associate in Surgery, Harvard Medical School (on leave of absence), and Dr. William S. Tillett, New York, New York, Professor of Medicine, New York University College of Medicine, and Chairman of the Committee on Convalescence and Rehabilitation of the Division of Medical Sciences, National Research Council.]

Immediately on announcement of the program of the Baruch Committee on Physical Medicine, widespread approval and enthusiastic endorsement of the project were received. Scientists and laymen alike have been prompt in praising this effort. This led Mr. Baruch to comment that he had never seen anything with which he had been connected—"even the work in the war"—receive such amazingly sympathetic treatment. Leaders in military medicine and in medical science in general gave enthusiastic approval.

Up until recently with regard to the advancement of physical medicine, as with the weather, everyone has talked about it but no one has done anything. Now it is apparent that something very definite is being done and that my opening statement is justified. At last the long delayed development of physical medicine seems to be at hand.

The more generic and more inclusive term "physical medicine" has now replaced the old designation "physical therapy." During the past year, practically all physicians' groups and publications dealing with this branch of medicine have dropped the designation "physical therapy" and substituted for it the term "physical medicine."

The Council on Physical Therapy of the American Medical Association changed its name to the Council on Physical Medicine; the Section on Physical Therapy of the Southern Medical Association has changed its name to the Section on Physical Medicine. Likewise, the American Congress of Physical Therapy has changed its name to the American Congress of Physical Medicine and the Society of Physical Therapy Physicians has changed its name to the Society of Physical Medicine. Finally the *Archives of Physical Therapy* has changed its name to *Archives of Physical Medicine* and the American Medical Association's new edition of its handbook on this subject will be changed from the old designation "Handbook on Physical Therapy" to the new term "Handbook on Physical Medicine." Also, the "Yearbook on Physical Therapy" is now called the "Yearbook on Physical Medicine." Therefore, we can say that it is now firmly established that this branch of medical practice shall be called "physical medicine."

One of the correspondents of the Baruch Committee, an experienced physician who has become profoundly impressed with the broad purposes of the Rehabilitation Program, suggests in the following quotation a new and enlarged conception of physical medicine:

It seems that there are two definite phases: first, physical medicine as it pertains to definitive treatment and how it can be utilized by the physician in the diagnosis and treatment of disease; second, and which I think is the more or less new concept as far as the general medical profession is concerned, its utilization in the broad field, taking up the dead space between definitive care and ability to return to productive work, the setup for retraining and reconditioning, medicine and its relation to environment, occupation, social status, etc. It is going to take physicians with real training and background to meet this special need; it should be the broadest of all medical specialties, utilizing as a basis for physical medicine the great potentialities of oneself. This would be more or less the science of how to use these potentialities and the art of such application.

In conjunction with the survey conducted

by the Baruch Committee on Physical Medicine to determine the needs for development of an adequate program of teaching and research in physical medicine, it became apparent that there was a need for better understanding of biophysics, electronics and instrumentation as applied to medicine on the part of the medical profession. With this thought in mind, after careful consideration of all aspects, the Administrative Board of the Baruch Committee on Physical Medicine recommended to Mr. Bernard M. Baruch, the sponsor of the Committee, that a special grant be made to the Massachusetts Institute of Technology for the establishment of special courses in biophysics, as related to medicine, for qualified practitioners of medicine. This grant was made by Mr. Baruch to the Massachusetts Institute of Technology, and courses which are free of tuition are now available at this institute for specially qualified young physicians who are interested in learning more about biophysics as related to the practice of medicine.

NEW DEVELOPMENTS IN MEDICAL ELECTROPHYSICS

During the course of our survey, I had the privilege of visiting, with the Chairman of our Research Committee, certain academic and commercial research laboratories, including the Department of Biology and Biological Engineering at the Massachusetts Institute of Technology. What we saw opened our eyes with regard to the possibilities of electrophysics as related to medicine in the postwar world.

At one research center there was a new 100,-000,000 volt electron accelerator. This device provides high velocity electrons corresponding to voltages all the way from 2,000,000 to 100,000,000 volts. For comparison, radium radiations correspond to about 2,000,000 volts. This new device provides radiation right up to the edge of the cosmic rays and will open up a whole new field for investigation in the realm of physical medicine.

We learned more about the new electronic tubes which will provide microwaves which can be projected as a beam. It is now possible to provide 10 kilowatts of high frequency power in wavelengths as short as 50 cm. or less. With these new electronic tubes, which can be obtained after the war, it will be possible to direct a beam of high frequency energy toward certain regions of the body. It is also possible to crossfire two or more such beams to obtain a high degree of localization of heat in a given bodily area. It will be possible to confine such a beam accurately. For example, at a wavelength of 20 cm. the beam would be localized on a spot of 5 cm. In other words, the diameter of the beam would be a fourth of the wavelength.

A study of the effect of microwaves, as produced by these newer types of electronic tubes, in heating of human tissues will certainly be a fertile field for investigation.

We discussed with the noted physicist, Dr. Irving Langmuir, his studies on surface phenomena and protein solutions. These studies will have many biologic applications. Single layers of molecules can be detected and measured and their properties studied. One can detect extremely small amounts of substances in solution. Studies on the roentgenographic diffraction patterns of proteins promise to throw much light on the structure of the protein molecule. Dr. Langmuir expressed the belief that, although much more work is needed, it is merely a question of time before the problem is unraveled.

Once the true structure of the protein molecule is determined, protein chemistry will be revolutionized. Under favorable conditions, this problem may begin to yield within ten years. Investigations along this line should be part of the program of basic medical research. A whole world of megamolecules and their unique properties will open before us. Langmuir expressed the opinion that eventually there will be a need for an "Institute of Megamolecules." X-ray and electron diffraction and electron microscopy will be employed chiefly at such an institute.

It was found that it is possible to make binaural hearing aids for deaf persons so that they could tell from which direction sounds were coming. With the currently employed monaural hearing aid, the deaf are unable to determine from which direction sounds emanate. Moreover, such binaural hearing aids permit discrimination between the sound source and reverberation and this is even more important than correction of directional defects.

Dr. Olson, an expert on acoustics, indicated that hearing aids might be made which would be operated from an ordinary alternating current household light socket. Such a device would be far superior to the small portable hearing aids now on the market, because it might use a directional type microphone and components having better acoustic performance. A person working for many hours at a desk might well appreciate having such a better quality hearing aid to which he could connect a wire whenever he chose to do so, thus supplementing his portable device.

We were shown an electronic recorder which can measure accurately periods of time from 1/100,000 of a second up to many seconds. This can be used medically to study reaction times.

We studied a photo-electric spectrophotometer which measures reflectance transmission against wavelength in millimicrons and records very accurately on paper the curves produced by various colors. This can be employed medically in the laboratory for study and solution of nearly all color problems and in making accurate color matching tests.

We observed a new integrating exposure meter which measures time against intensity of radiation. This device can be employed in connection with radiation therapy to make dosage much more accurate.

We saw new types of cathode ray oscillographs which are extremely useful in electromedical research for studying the characteristics of electric circuits.

We examined experimental models of electron

microscopes which had been so modified in size and construction that it was predicted that eventually we shall have electron microscopes which will cost less than \$5,000 and which will come in table models or will fit into a suitcase.

We talked with Dr. Hillier, who has contributed greatly to the development of the electron microscope. The latest model will provide magnifications of 5,000 within the instrument of such definition that one can then obtain additional useful magnification of 15 to 20 times by photographic enlargement so that one may still get a clear picture of an object which has been magnified as much as 100,000 times. The medical possibilities are almost beyond imagination.

Dr. Hillier showed us his electron micro-analyzer, an electron microscope in conjunction with which a very small beam of electrons, which he calls an "electron probe," can be directed to small regions of the field being examined. The electronic energy absorbed by the specimen gives information about its chemical composition. Thus one can analyze extremely small microscopic substances. Hillier mentioned jokingly that, with this electron probe, it would be perfectly possible for one to write his signature on a bacterium. The diameter of the beam of the probe is only about 20 Angström units. This analyzer may open other vast fields of medical physics.

We learned from radio engineers that amplifiers for the measurement of nerve impulses will be available which permit oscillographic recording of nerve currents with great fidelity of wave shape over a wide range of frequencies.

Dr. Brown, expert on high frequency currents, told us that there were great possibilities for quick sterilization of surgical instruments by means of high frequency coils. Very short periods of exposure to intense "shots" of power could be utilized. The method has already been used for quick sterilization of drinking glasses. Intense sterilizing heat can be applied in a second or less. (In "flash pasteurization" of

milk, the milk can be heated by the high frequency current to a temperature of 190° F. in four fifths of a second.)

We may conclude then, I think, with Mr. Engström, a leading radio engineer, that what is needed is for physicians to make use of the physical tools which have already been developed. He said: "The main thing lacking is proper liaison between radio engineers and physicians." Physicians who are interested in research in physical medicine should become familiar with the field of modern electrophysics and then pick out the tools in the electric research laboratory which will be of value in therapy and in medical research.

THE ROLE OF PHYSICAL MEDICINE IN REHABILITATION

Physical medicine is playing an ever increasingly important role in physical rehabilitation of those disabled by the war. In closing, I should like to quote the statement on rehabilitation made by John Galsworthy at the Allied Conference on the After-care of Disabled Men, Washington, D. C., in December, 1919. Galsworthy said:

Restoration is at least as much a matter of spirit as of body, and must have its central truth:—Body and

spirit are inextricably conjoined. To heal the one without the other is impossible. If a man's mind, courage and interest be enlisted in the cause of his own salvation, healing goes on apace, the sufferer is re-made; if not, no mere surgical wonders, no careful nursing, will avail to make a man of him again. Therefore I would say: "From the moment he enters the hospital, look after his mind and his will; give him food; nourish him in subtle ways; increase that nourishment as his strength increases. Give him interest in his future. Light a star for him to fix his eyes on, so that, when he steps out of the hospital, you shall not have to begin to train one who for months, perhaps years, has been living, mindless and will-less, the life of a half-dead creature."

That this is a hard task none who knows hospital life can doubt. That it needs special qualities and special effort, quite other than the average range of hospital devotion, is obvious. But it saves time in the end, and without it success is more than doubtful. The crucial period is the time spent in the hospital. Use that period to recreate not only the body, but mind and will power, and all shall come out right; neglect to use it thus and the heart of many a sufferer and of many a would-be healer will break from sheer discouragement. A niche of usefulness and self-respect exists for every man however handicapped; but that niche must be found for him. To carry the process of restoration to a point short of this is to leave the cathedral without spire. To restore him, and with him the future of our countries, that is the sacred work.

Truly the future of physical medicine looks exceedingly bright.

MENTAL HEALTH*

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VER 150,000 persons are admitted to the mental hospitals of this country annually! Fully one half of the civilian hospital beds are in mental institutions. Of every 20 persons over 15 years of age the chances are that 1 will at some time during his life become a patient in a mental hospital. These few statistics, startling as they are, however, merely serve to indicate the size of one corner of the field of psychiatry, that which deals with persons so seriously maladjusted that for a period at least they must be withdrawn from the stresses of everyday life to a milieu in which they may be helped to regain their mental equilibrium. Substantial advances have been made in recent years in the intramural treatment of mental disorders, and the general results of such treatment are steadily increasing the discharge rate of the mental hospitals, but in the few minutes allotted to me I would prefer to invite your attention to the prophylactic and community aspects of psychiatry, the segments of the problem which are, or should be, of interest to the general practitioner of medicine.

The major problem of treatment in psychiatry is not the psychoses; it is rather that vast group of partial maladjustments, generally referred to as psychoneurotic, the hysterias, the anxiety states, the phobias, too often presenting various physical symptoms the psychogenic nature or aggravation of which may elude the attention of the physician. A new term, psychosomatic medicine, has recently achieved some currency, and even recently "made" the pages of *Life*—an ambivalent medical accolade! This complicated term is merely a new name for an old thing, something practised by the medical man of a century ago before

the days of overspecialization, namely, consideration not only of the physical make-up of the patient but his emotional make-up and his environmental stresses as well; for, if psychiatry has gained reassurance from another specialty, it is preëminently in the demonstration by the physiologists of the powerful influence of emotional states upon the functioning of the organs and systems of the body. We have learned much from Freud and his followers of the dynamics of the neuroses, and recent developments in military psychiatry, which deals very largely with neurotic states, have taught us new and effective methods in brief therapy of both the individual and group varieties.

In another group of disorders may be mentioned alcoholism. Recently hereabouts an old truth has been rediscovered, namely, that to treat the alcoholic as a criminal offender by sentencing him to repeated short stays in jail is worse for him and for society than doing nothing. Accordingly, a movement looking to the establishment of clinics for alcoholics has developed with promise of fulfilment, at the basis of which lies the recognition of the fundamental fact that continued overindulgence in alcohol is largely a medical problem. There are various reasons why people drink too much, but it can safely be said that the question why is in a good many cases one which can be answered, if at all, by the psychiatrist. The Society has just officially gone on record as endorsing the establishment of clinics and of special institutions for the intramural treatment of alcoholics when such treatment is called for as a medical, not a criminal, matter.

One of the most significant developments in preventive psychiatry in the past quarter century is the rise of the child guidance move-

*Presented under the auspices of the Committee on Public Health before the Society, March 14, 1945.

ment. The study of mental mechanisms has demonstrated that the roots of mental breakdown are often manifested in early life in such forms as shyness and recessiveness, undue day-dreaming, persistent enuresis, or abnormally aggressive behavior. Such traits, formerly often "left to nature" in the hope that the child would outgrow them, impair the social, school and home adjustment of the child, to the despair of teacher and parent, yet in many cases they are amenable to treatment. At present there are two excellent child guidance clinics in Washington. The Washington Institute of Mental Hygiene, in the establishment of which the late Dr. William Alanson White was instrumental, is an agency of the Community Chest under the direction of Dr. Rex E. Buxton. The other clinic is operated at Catholic University under a grant from the Rockefeller Foundation; Fr. (Dr.) Thomas Verner Moore is the director. The applicability of the technics of child guidance to the many problems of school adjustment, apparent mental retardation, misbehavior of various sorts, should be obvious. It is my earnest hope that eventually the school system of the District, so progressive in many ways, may institute modern psychiatric services as a part of its organization.

The application of psychiatric procedures to problems of behavior is well illustrated in the juvenile court clinics, now operating in many centers, and fairly recently established in the District (although here its tenure of life seems to hang in the balance with the proposal of each District budget!). The questions of behavior proposed to the Juvenile Court are not unlike those which come to the child guidance clinic, except that they come through an official source and often involve the less fortunate strata of our society. In order to make an intelligent disposition, the judge should have available data concerning the mental and social needs of the child, and an assurance that if continuing psychiatric treatment is required it can be provided. The provision of this facility is in

the broadest sense preventive social psychiatry, a protection to the community against the juvenile's becoming an adult recidivist. An excellent clinic is now operating in our Juvenile Court, and being kept fully occupied; to disturb it or to abolish it in the expectation that some other to-be-established clinic may be able to do the needed work for the court in its spare time would, in my opinion, be little short of tragic.

Of the application of psychiatric service to personnel matters in industry much might be said; it is a new and growing field of great promise. So, too, one might elaborate on the function of psychiatry in the Courts and in correctional institutions, juvenile and adult; the federal prisons, as you probably know, have long been provided with psychiatric services, and so have those of some of the more progressive states. There are aspects of the problem, however, which must be passed over for lack of time and because they are not directly in line with this audience's interests.

In the mental health of the public at large, and of the returning veteran in particular, we are all interested. First let me say that I know of no evidence which demonstrates a general increase in civilian mental breakdown directly due to the stresses of war. That everyone has increased anxieties, stresses and griefs as a result of this devastating conflict is all too true, but the resilience of the human personality is daily being demonstrated. As the demands increase, new resources seem to be tapped, although we must always remember that everyone, even the strongest of all, has his breaking point, no matter how nearly invulnerable he may appear.

As for the returning veteran, such figures as to mental breakdown as have been made available are high, and some alarming statements have been made upon the basis of these data. Without minimizing the fact that mental breakdown in the armed forces is a large problem, it is

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STUDIES ON NEUROMUSCULAR DYSFUNCTION

VI. Neostigmine Therapy of Neuromuscular Dysfunction*†

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NEOSTIGMINE is one of a series of drugs which specifically inhibit the enzyme cholinesterase. The function of cholinesterase is to split acetylcholine and thereby inactivate it. Neostigmine by inhibiting cholinesterase allows the accumulation of acetylcholine at nerve endings and in that way produces profound functional changes in many different parts of the body. Acetylcholine is recognized as an extremely important physiologic substance because it is responsible for transmission of nerve impulses to smooth muscles and glands in the parasympathetic nervous system; it is responsible for transmission of excitation from nerves to skeletal muscles; and plays a role of importance in transmission of excitation from nerve cell to nerve cell across the synapse.

Neostigmine has been used for a number of years to increase intestinal peristalsis and stimulate the urinary bladder through inhibition of cholinesterase at parasympathetic nerve endings.

Neostigmine has an established place in the therapy of myasthenia gravis.¹ In this disease, there appears to be a defect in conduction at the myoneural junction which can be corrected by neostigmine.² Fatigue and weakness in myasthenia gravis are overcome by neostigmine apparently as a result of the action of this drug on cholinesterase at the myoneural junction, resulting in facilitation of the passage of excitation to the skeletal muscle. In the treatment

of myasthenia gravis, neostigmine is routinely administered orally without atropine. Relief of fatigue and weakness is evident within an hour after administration of the drug, and the effect persists for only 4 to 6 hours. Continuous treatment is necessary, and if the drug is discontinued the symptoms rapidly recur.

NEW DEVELOPMENTS IN NEOSTIGMINE THERAPY FOR NEUROMUSCULAR DISORDERS

In 1943, Kabat and Knapp³ introduced neostigmine in the treatment of poliomyelitis. They demonstrated that this drug decreases muscle spasm (muscular hypertonus and proprioceptive reflex hyperirritability) and inhibits incoördination in poliomyelitis. In some instances striking improvement in strength of voluntary motion was observed. They showed that therapy with neostigmine brought about acceleration of recovery in subacute and chronic cases of poliomyelitis. The therapeutic effect of neostigmine in infantile paralysis was not nullified by atropine, and the improvement was usually retained after treatment was discontinued. These observations have since been confirmed.⁴

More recently these studies have been expanded to cover a wide variety of disabilities in which neuromuscular dysfunction plays a prominent role. Neostigmine has been shown to relieve muscle spasm, spasticity, contracture, muscular pain, weakness, incoördination and fatigue in chronic rheumatoid arthritis,^{5,6} following fractures and other injuries,⁵ hemiplegia,⁵ spastic cerebral palsy,^{5,7} subacromial bursitis,⁵ facial paralysis,⁵ stiff neck,⁸ and low back pain.⁹

* From the Hospital Division, United States Public Health Service.

† Read before the Section on Neurology and Psychiatry of the Society, April 5, 1945.

At the present time 430 cases of various types of neuromuscular disability have been treated in the United States Public Health Service in this investigation. This program was begun by the author and has been continued with the assistance of Senior Assistant Surgeon (R) Charles W. Jones. Almost all of the patients observed have suffered from chronic disability, frequently of many years' duration, which had failed to respond to all other methods of treatment. A majority of these patients have benefited significantly and a few patients have improved dramatically from neostigmine therapy.

The duration of the disability does not appear to make a great deal of difference in the therapeutic effect of neostigmine on neuromuscular dysfunction: one patient under treatment at present has a spastic cerebral palsy from a birth injury of the brain and is now 31 years of age; another patient has a hemiplegia of 31 years' duration; another patient had arthritis for 27 years; all of these patients have shown significant improvement from several weeks of neostigmine therapy. Considering the wide variety of conditions which have benefited from neostigmine therapy, it is evident that this drug is capable of relieving certain types of neuromuscular disorders regardless of their etiology or location and dependent only upon the character of the disability. Atropine is used routinely with neostigmine to prevent unpleasant parasympathetic side-effects, but the atropine does not appear to influence the action of neostigmine on the neuromuscular condition. As a rule the improvement is retained after neostigmine therapy is discontinued.

The drug has been given routinely by daily intramuscular injection using a dosage of 2 c.c. of Neostigmine Methylsulfate 1:2,000 solution (1 mg.) together with atropine sulfate $\frac{1}{150}$ grain. Some patients have been given only 1 c.c. of neostigmine with $\frac{1}{200}$ grain atropine, while others have taken as much as 3 c.c. of neostigmine with atropine $\frac{1}{150}$ grain. Neostigmine may also be efficacious when given by mouth and has been given 3 times a day in

doses of 15 mg. without atropine or 30 mg. together with $\frac{1}{200}$ grain of atropine or even as high as 45 mg. together with $\frac{1}{150}$ grain of atropine 3 times a day. The dosage should be adjusted to the individual and built up to his tolerance.

A word of caution is in order in using large doses of neostigmine as reported in this study. While only insignificant and minor reactions have been observed in almost all of these patients, and the patients have frequently continued their daily occupation, neostigmine is a powerful drug and the physician must keep a close watch for symptoms of toxicity.¹⁰ A few patients are sensitive to small doses while others take large amounts of neostigmine without showing any toxic reactions. A safe procedure is to start with a small test dose of neostigmine and atropine and build up and adjust the dosage according to the tolerance of the individual patient. Patients given neostigmine and atropine must be seen at frequent intervals to avoid toxic reactions. Viets,¹¹ who has had extensive experience in the use of neostigmine in the treatment of myasthenia gravis, stated recently that no patient is known to have died from neostigmine.

A. Post-Traumatic Neuromuscular Dysfunction.—Following fracture and immobilization, limitation of joint motion, muscle cramps, pain in joints and muscles, weakness and fatigue may in some cases persist for years and fail to respond to physical and other types of therapy. In many such chronic disabilities in which the outlook has been poor, or even hopeless, neostigmine has been responsible for striking improvement. Rapid increase in range of motion, relief from pain and cramps and marked improvement in strength and endurance have been observed from several weeks of neostigmine therapy. The improvement has in almost all instances been retained after treatment was discontinued. Pain originating in bone as in fracture of the os calcis has not responded to neostigmine. Fibrous or bony ankylosis and bony block have not improved with this treat-

ment. Proper selection of cases of disability following fractures for neostigmine therapy is therefore of paramount importance since the drug can only influence the neuromuscular dysfunction associated with the condition.

The neuromuscular dysfunction associated with acute and chronic ankle sprain, acute and chronic lumbosacral and sacroiliac strain, chronic disability after meniscectomy, etc., has shown significant improvement from neostigmine therapy. The specificity of the effect of the drug on neuromuscular dysfunction is demonstrated in ankle sprains by the fact that relief from pain and increase in range of motion may not be associated with any improvement in ankle swelling.

B. Spastic Paralysis.—In chronic cases of hemiplegia and cerebral palsy the results of neostigmine therapy have been highly encouraging. One patient 31 years of age, with a birth injury of the brain, who had dragged his foot for many years, now walks lifting the foot off the ground at each step after only 3 weeks of neostigmine therapy. He is able to oppose the thumb to the ring and little fingers of the right hand, which formerly was impossible. In chronic cases of upper motor neuron lesions, even after the lapse of many years, relaxation of spasticity, decrease and even disappearance of resistance to passive motion, relaxation of old contractures and improvement in deformity, and improvement in strength and coordination have been observed during neostigmine therapy. The improvement has usually been retained after treatment was stopped. In addition, improvement has been observed in chronic dysarthria, dysphagia and facial paralysis resulting from cerebral lesions. One patient with a hemiplegia and a hemihypesthesia of 2 years' duration has shown a remarkable improvement in position sense from neostigmine therapy. In a field in which the outlook has been poor and more often hopeless the advent of neostigmine therapy should represent an important advance. In spastic disorders intensive and specialized muscle training should be given along with

neostigmine therapy to obtain maximum improvement.

The possibilities of neostigmine therapy in spastic cerebral palsy are highly encouraging. In several adult patients with disability from cerebral palsy of many years' duration, significant improvement in muscle function has resulted from neostigmine therapy. In children with cerebral palsy Schaubel⁷ has reported remarkable improvement from oral neostigmine administration. I quote an important section of his recent paper: "The 10 patients who have received prostigmine for 8 months had been followed in the outpatient clinic of the hospital for a number of years. All had been in the hospital from 5 to 12 months before the drug was used. All were severe tetraplegics; the ages were from 6 to 14 years. Their muscle training program during the hospital period preceding medication had been carefully followed, and little progress had been noted despite the use of all possible surgical procedures indicated in each case. These included tenotomies, neurectomies, stabilizations and tendon transplants. Furthermore, during the premedication hospitalization all had to be fed by an attendant, and though all could utter sounds, none could be understood. Within 3 weeks after instituting prostigmine therapy, a definite decrease in muscle spasm, overflow and incoördination was noted in each of the 10 patients. Seven patients who had never walked without the aid of anchored walking bars began using the mobile walker, and 2 months after the beginning of treatment all 7 were walking with crutches with no other aid. Three patients who despite surgery and intensive physiotherapy never had been able to walk even with the anchored walking bars, improved so rapidly that within 10 weeks all 3 were using the mobile walker with good ambulation. At this writing 6 patients walk using no artificial aid. Three are using crutches and get about nicely without aid from the attending staff. One patient is using crutches but as yet cannot ambulate freely about the ward or physiotherapy gymnasium without supervision.

"None of the above 10 patients could talk and be understood by any of the house staff despite 5 months or more of training in phonetics by our school teaching staff. However, within 6 weeks after the initial prostigmine medication 9 patients could say understandable words, and after 8 months of prostigmine therapy plus further training in phonetics only 1 patient has difficulty in speech although with patience one can carry on a simple conversation with her.

"Because of marked muscle spasm, overflow and incoördination all 10 patients had to be fed by an attendant during their hospital stay previous to prostigmine medication. Within 9 weeks after starting the drug 7 patients could feed themselves and needed aid only in drinking. Within 4 months 9 patients were feeding themselves and 7 were able to drink liquids without attendant aid. After 8 months 9 patients eat and drink without help and the remaining 1 needs assistance only while consuming liquids."

The encouraging results with neostigmine in hemiplegia and cerebral palsy immediately suggest the possible value of the drug in similar spastic disorders in such chronic neurologic diseases as multiple sclerosis, amyotrophic lateral sclerosis, lateral sclerosis, and subacute combined degeneration of the spinal cord. Experience with these conditions has been too limited as yet to allow an opinion as to the value of neostigmine.

C. Arthritis.—In chronic rheumatoid arthritis neostigmine has been of value in relieving pain localized in joints as well as muscles, in relaxing muscle spasm, increasing range of motion and decreasing deformity, overcoming fatigue and increasing strength of voluntary motion. The response in any particular case depends on the extent to which muscle spasm and disuse atrophy play a rôle in production of the symptoms. Fibrous or bony ankylosis, subluxation, joint swelling and the associated pain, the arthritic process, as well as the general health of the individual are apparently not affected by neostigmine therapy. In many cases of chronic rheumatoid arthritis the neuromuscular factor

is of major importance in the disability, and improvement in this aspect of the condition from neostigmine therapy will greatly improve the motion and locomotion of the patient. It must be emphasized that cases of arthritis selected for treatment with neostigmine must be analyzed with great care for neuromuscular dysfunction and selection made and prognosis decided on that basis.

In chronic Marie-Strumpell's arthritis neostigmine therapy appears promising. In a series of cases with ankylosis of the spine from arthritis of many years' duration neostigmine therapy has resulted in relief from pain, increase in range of motion in the neck and extremities, striking increase in strength and relief from fatigue. There has been no change in the ankylosed vertebral column either on physical examination or roentgenographic examination. The improvement has usually been evident after 1 month of treatment and in some of the cases transformed the individual from a chronically fatigued, weak person suffering pain and limited motion to a more active, energetic individual, capable of carrying on with ease many activities which formerly were impossible. It is important to emphasize that adequate dosage of the drug is necessary in such cases and that immediate improvement is not often to be expected.

In chronic cases of bursitis of the shoulder and knee a number of patients have shown significant improvement in range of motion, strength and relief from pain from neostigmine treatment, while others have failed to benefit from this therapy.

No benefit has been observed from neostigmine in acute rheumatoid arthritis. In hypertrophic arthritis some patients have shown significant improvement while others did not respond. The experience with specific infectious arthritis and gout has been too limited as yet to warrant a statement.

D. Poliomyelitis.—The value of neostigmine in the treatment of infantile paralysis was first demonstrated by Kabat and Knapp.³ Further

studies have been reported by Boines⁴ and Eveleth and Ryan.¹² In subacute and chronic cases of poliomyelitis neostigmine will relax muscle spasm, increase range of motion, cause deformity to improve or disappear, improve coördination, increase strength and decrease fatigue. The drug is effective in improving neuromuscular dysfunction in poliomyelitis even many years after the original infection. To obtain the best results specialized muscle training must be given along with neostigmine.

Selection of cases of poliomyelitis for neostigmine therapy is complex. The drug will frequently increase range of motion and decrease deformity associated with muscle spasm or persistent muscle contraction, but will not affect fibrous contracture associated with severe muscular atrophy from motor denervation. Neostigmine may increase strength or even initiate motion in muscles suffering disuse atrophy and alienation, but obviously it cannot improve or restore function lost through destruction of anterior horn cells in the spinal cord.

The value of neostigmine in acute cases of infantile paralysis is not finally settled. A number of observers have had the impression that in particular cases acceleration of recovery ensued from neostigmine administration. Because of the great variability in the course and prognosis in different patients with poliomyelitis a carefully controlled study on a large series of cases would appear to be necessary in order to establish beyond any doubt the value of any type of therapy in the acute stage of this disease.

E. Facial Paralysis.—In chronic facial paralysis resulting from Bell's palsy, basal skull fracture, etc., definite improvement has been observed from neostigmine therapy even in cases of as long as 10 years' duration. A patient now under treatment had the intracranial portion of the facial nerve removed with an acoustic neuroma and an anastomosis was made of the spinal accessory with the facial nerve more than 3 years ago. This woman has

shown striking improvement in voluntary motion of the facial muscles on the paretic side from only a few weeks of neostigmine therapy. In facial paralysis the favorable cases for this treatment are those in which anatomic regeneration of the nerve has occurred to a greater extent than is reflected in functional recovery. The improvement with neostigmine in chronic facial palsy will therefore vary from case to case and be more significant in some cases than in others.

F. Summary of Recent Advances in Neostigmine Therapy for Neuromuscular Dysfunction.

1. Inhibitory effects:

- a. Inhibition of spasticity in hemiplegia and cerebral palsy.
- b. Inhibition of muscle spasm and the pain associated with muscle spasm in post-traumatic disability, intramuscular fibrositis, chronic rheumatoid arthritis, bursitis, poliomyelitis, etc.
- c. Inhibition of muscular contracture even after the lapse of many years in hemiplegia, cerebral palsy, poliomyelitis, arthritis, and post-traumatic disability.
- d. Inhibition of muscle cramps, associated with poor circulation in the extremities or post-traumatic disability.
- e. Inhibition of incoördination and motor overflow in cerebral palsy, poliomyelitis and hemiplegia.

2. Facilitating effects:

- a. Facilitation of voluntary motion resulting in increase in strength, initiation of motor function and decrease in fatigue in post-traumatic disability, poliomyelitis, hemiplegia, cerebral palsy, facial paralysis, arthritis and bursitis.
- b. Facilitation of sensory function in a patient with chronic hemihypesthesia from a cerebrovascular accident.

3. a. Neostigmine therapy for neuromuscular dysfunction has been effective in chronic cases of many years' duration.

- b. The improvement in chronic cases has,

as a rule, been retained after therapy has been discontinued.

- c. The effects of neostigmine on neuromuscular dysfunction are not nullified by atropine, and atropine is used routinely to eliminate the unpleasant parasympathetic side-effects of neostigmine.
- d. Larger doses of neostigmine than have generally been used previously are usually necessary in the treatment of neuromuscular dysfunction.

MECHANISM OF ACTION OF NEOSTIGMINE IN NEUROMUSCULAR DYSFUNCTION

A. Action at the Myoneural Junction:

In myasthenia gravis convincing evidence has been presented² that the therapeutic action of neostigmine is localized at the myoneural junction. It is also known that neostigmine acts at the myoneural junction in normal individuals in small doses as a stimulating agent but in larger doses inhibits transmission of excitation.¹³

However, it is very difficult to explain the effects of neostigmine on neuromuscular dysfunction in hemiplegia, cerebral palsy, poliomyelitis, facial paralysis, arthritis, post-traumatic disability, etc., by action of the drug at the myoneural junction:

1. Inhibition and facilitation have been observed in the same muscle at the same time.
2. The persistence of improvement after treatment is stopped is not seen in myasthenia gravis where the action is at the myoneural junction.
3. The effect of neostigmine is slower in onset and more persistent than is to be expected from action at the myoneural junction.
4. It is impossible to explain inhibition of motor overflow, incoördination, and reflex hyperirritability by action of neostigmine at the myoneural junction.
5. It is impossible to explain facilitation of sensory function by action of the drug at the myoneural junction.

B. Action of Neostigmine on the Central Nervous System:

Schweitzer and Wright¹⁴ demonstrated in animal experiments that neostigmine, acting directly on the spinal cord, has an inhibitory effect on the knee jerk and can inhibit strychnine convulsions. These central effects of neostigmine were not influenced by administration of atropine. The central action of neostigmine was considered the result of inhibition of cholinesterase. Kremer¹⁵ administered neostigmine and neostigmine and acetylcholine intrathecally to patients with hemiplegia. The spasticity and hyperactive deep reflexes were strongly depressed by neostigmine. Evidence was presented that the effects observed were the result of action of the drug directly on the spinal cord. Large doses of acetylcholine in the spinal fluid were without effect. Small doses of neostigmine strongly potentiated the action of acetylcholine and brought about the inhibition of spasticity and deep reflexes. These observations led to the conclusion that neostigmine has a powerful central inhibitory action by virtue of inhibiting cholinesterase and allowing accumulation of acetylcholine at synapses. Ward and Kennard¹⁶ reported that monkeys subjected to excision of the motor cortex recovered motor function more rapidly when given a cholinergic drug (doryl). The effect was not blocked by atropine and the improvement persisted after drug administration was discontinued. They suggested that the acceleration of recovery of motor function was the result of inhibition of cholinesterase at synapses in the central nervous system. Kabat and Knapp³ also studied the mechanism of the inhibitory action of neostigmine. They observed an inhibitory effect on muscle spasm from intrathecal administration of neostigmine; they showed that the effect was not blocked by atropine; and that decrease in incoördination and reflex hyperirritability could not be explained by action of the drug at the myoneural junction. They therefore suggested that the inhibitory action on muscle spasm and incoör-

dination in poliomyelitis could best be explained as an action of the drug at synapses in the spinal cord.

It is evident that neostigmine has a powerful effect on the central nervous system by an action at synapses. All the available evidence indicates that neostigmine has this central action by virtue of its ability to inhibit cholinesterase. It appears likely that the inhibitory and facilitating effects of neostigmine observed in various types of neuromuscular dysfunction (excluding myasthenia gravis) are the result of the central action of the drug.

The central action of neostigmine can explain changes in coordination and sensation. The central effect is not inconsistent with inhibition and facilitation appearing in the same muscle simultaneously, since the inhibition could occur in one pathway and the facilitation in another pathway. The persistence of improvement after treatment is stopped can be thought of as resulting from the opening up of new pathways in the central nervous system which continue to function after facilitation is discontinued just as new pathways are developed in formation of habits. The therapeutic effect of neostigmine on neuromuscular dysfunction is not blocked by atropine; and atropine has no influence on the central action of neostigmine.

The application of the central action of neostigmine to the therapy of neuromuscular dysfunction of various types appears to open new and hopeful horizons. The opening up of new pathways in the central nervous system in cerebral palsy has resulted in dramatic improvement in cases of many years' duration which had been considered hopeless. Definite, rapid, and in many instances striking benefit

has been derived from neostigmine therapy in acute and chronic cases of the most common types of disability involving motion and locomotion. The investigation of neostigmine therapy in these disorders raises many questions concerning the nature of and mechanisms involved in chronic physical handicaps in which neuromuscular dysfunction plays an important role. One may even hope that deeper understanding of the fundamental nature of chemical mediation of synaptic transmission may help to solve some of the many mysteries of the functioning of the human brain.

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A SIMPLE METHOD FOR DISPOSING OF A DIRECT INGUINAL HERNIA SAC

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THE disposition of the hernia sac in the repair of a direct inguinal hernia has always been troublesome for the surgeon. Many methods have been used, none entirely satisfactory. Some operators feel that what is done with the hernia sac is of no consequence in the cure of the hernia and as a result leave it undisturbed. This is undoubtedly the easiest course to take, because opening a direct hernia sac presents several inherent difficulties. The extraperitoneal fat usually makes it difficult to bare the peritoneum cleanly, and one always has the fear that he is inadvertently performing a cystotomy. However, most authors of the standard textbooks of surgery state that with a large direct hernia the sac should be opened, the contents reduced and the excess portion of the sac excised.^{1, 2, 3, 4} The problem of how to close the defect in the peritoneum then presents itself. It is not feasible to ligate and transfix a peritoneal sac with a wide base, and the friability of the peritoneum in this area often makes it difficult to maintain a good closure with any type of suture.

A method which has been in use⁵ and which seems satisfactory in that it completely and easily eradicates the direct hernia sac without the necessity of opening the peritoneum in Hesselbach's triangle is the conversion of a direct sac to an indirect one. This procedure has been in use almost universally when a so-called pantaloon hernia is present. Nevertheless, it does not seem to be generally known that a pure direct hernia may be treated the same way and with equally satisfactory eradication of the direct

sac. The procedure is carried out as follows: A hemostat is slipped down between the spermatic cord and inferior epigastric vessels and the peritoneum grasped. The peritoneum is then pulled up and opened between 2 hemostats. The index finger of the right hand, if it is a left hernia, or the index finger of the left hand, if it is a right hernia, is placed in the opened peritoneum. Gentle traction is then made on the medial wall of the sac of the artificially created indirect hernia. At the same time the inferior epigastric vessels are pushed downward using a gauze sponge in the free hand. This maneuver causes the peritoneum of the direct portion of the hernia to travel under the inferior epigastric vessels so that the direct sac disappears and only an indirect sac remains. The indirect sac can then be disposed of in the usual manner.

This method has been found satisfactory for all direct inguinal hernias except for the type which has a relatively narrow neck with the sac protruding through a small clear-cut defect in the transversalis fascia. Although this variety of direct hernia is uncommon, it is the type which most often becomes strangulated.⁶ And if the hernia is strangulated at the time of operation, it is usually necessary to open the sac directly.

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President's Page

MEDICINE MUST NOT BE COMMERCIALIZED

There is no subject on which doctors are more sensitive than that of fees. Somehow they feel that this is a personal matter which concerns them individually. It is something which must be decided between themselves and their patients. No one can quarrel with this position. In fact, it is sound, except for one thing, and that is that a minority of physicians have been guilty of commercializing medical practice. In other professional fields this would not be so serious, but where the health of a community is concerned it is another matter.

It is this latter group which has brought condemnation upon the medical profession, which creates ill will for the vast majority who are fair in their financial transactions with patients. There would be no point in bringing this matter to the attention of our membership were it not for my feeling that we should not gloss over this problem. We had best face it, doing what we can to eliminate commercial practices. After all medicine is not a business but a high calling. When physicians forget this they do their profession and their patients a disservice.

Another thing, physicians should remember that patients come to them not because they want to but because they have to. It is easy enough to say that the individual should save for the day when he may be taken with a serious illness, but very few do. Even doctors are not notably farsighted in this respect. It is an unpleasant thought which most people do not wish to dwell on anyway. And then it will perhaps happen to someone else.

Considering this attitude of mind, may I suggest that the following rules be observed by physicians where fees are concerned:

1. Charge a *fair* fee for your services. Where a large bill is to be incurred, speak to the patient about it. He will appreciate your doing so.
2. If a patient thinks your bill is too high, reduce it. You can't lose by doing so. Too many doctors waste time and energy trying to collect a fee just because of the principle involved.
3. Suing a patient for a fee can seldom be justified. The physician need not be told that the publicity that may ensue and the discussion which often follows may do him more harm than good.

This is my last message to you as Acting President. It has been a privilege to act as head of our organization if even for only a few months. As you have elected me to the Executive Board, I will continue to serve in an official capacity, and you can be sure I will do it to the best of my ability.

Wm. M. Ballinger

ACTING PRESIDENT

Editorials

THE GRIEVANCE COMMITTEE REPORTS

At the end of another year your Grievance Committee wishes to comment briefly on its activities. There has been a definite increase in the number of complaints submitted to the Committee for adjustment as compared to previous years, and it has been found necessary to devote more than the usual time to their study, and to the correspondence and conferences related to them. The outstanding feature of most of the communications is still the matter of "fees." This is not a new observation on our part as it has had a place in our comments to the Society before. The fact that a similar situation apparently prevails in the medical societies in other cities makes us all the more anxious that not only complaints but, still more important, even an apparent basis for them should be eliminated as far as possible.

While each instance differs from the others, the central theme is essentially the same, and indicates that some patient feels that he has not received medical service consistent with the amount charged. Perhaps the physician has submitted his statement without taking into account the special circumstances or the unusual conditions under which the service was rendered. In a number of cases the patient has registered his complaint with the Committee without talking the matter over with his physician.

When the Committee has urged such discussion, a number of disagreements have been composed with satisfaction to all parties. Others have been adjusted through "hearings" or correspondence with the patient and physician. These results strongly point to the advantage of ready access to the physician himself when questions between patient and physician arise,

particularly in regard to this frequently troublesome subject of "fees."

The Committee has been impressed by the interest of individuals who, as onlookers during the doctor's visit, or, as friends or relatives, feel the patient has a grievance against a physician. Doubtless some of the comments thus expressed to your Committee have been made without consulting the patient.

We must approach the situation from two viewpoints, one as concerns our normal stationary population, if indeed one can consider any group of people living in quite normal conditions today; the other, as regards our great body of transients, consisting largely of war workers, many of them members of the military forces. We would not suggest that the treatment of these two groups be in any way different, unless even more meticulous attention be shown our visitors. We have many "strangers within our gates," most of them under the tension of going from home to war, or living under inconvenient, perplexing wartime conditions. Most of them, too, are under the watchful eye of the folks at home who are alert to any indication of unhappiness in those whose return they anxiously await.

Your Committee has given much thought to the relation between our profession and these visitors and has taken considerable pains to study the methods adopted in providing medical service to guests in our hotels. We are convinced that reason for complaint in this direction is indeed the exception. By and large, our members have made only nominal charges for their service, have made none at all, or have been careful to ascertain the economic status of

the patient when called upon by our hotel managers or when attending patients who have called them directly. They have been particularly scrupulous in dealing with members of the armed forces. We would urge our colleagues to continue to be watchful of the manner in which the service is rendered, as well as its quality, so they will constitute an expression of welcome and a cordial invitation to come to Washington again. This will serve not only to correct but to prevent any misunderstanding or unhappiness.

Our experience confirms our earlier belief that in the greater proportion of disagreements, both parties feel they are in the right. The readiness with which compromise may usually be effected likewise convinces us most disagreements might be avoided or adjusted without the intervention of the Grievance Committee.

We are always happy to be of service. We are happier still when we are not needed.

JANVIER W. LINDSAY, M.D.

Chairman, Grievance Committee

ADOPTION LAW NEEDS CLARIFICATION

Congress, on April 22, 1944, enacted Public Law 292 for the purpose of regulating the placing of children in family homes, among other things, for adoption purposes. This Act was passed for the obvious purpose of preventing "brokerage" in the placing of children in homes for adoption.

It seems that in the past, persons with knowledge that a child is available for adoption have solicited prospective adopting parents and have obtained monies from such persons for placing with them a child or children for adoption. In some instances, large sums of money have been extracted from childless persons who are unable to have a child of their own.

It is this reprehensible practice that Public Law 292 was enacted to prevent. Physicians in their practises constantly become aware of situations in which a child is available for adoption. Because of this fact, it is important that every physician should be familiar with the terms of Public Law 292.

Briefly, the Act provides that before any person can engage in arranging or assisting in placing or arranging for the placement of a child under sixteen years of age in a family home or for adoption, such person must be licensed as a child placing agent or agency, pursuant to the terms of the Act.

Section 5 of the Act is very sweeping in its

terms and forbids placing, arranging or assisting in placing or arranging for the placement of a child under sixteen years of age in a family home or for adoption by any person not licensed so to do.

Section 8 of the Act provides criminal penalties for any violation of the Act.

While the Act seems to have been passed to cover persons, firms, corporations, associations or agencies that receive or accept a child and place or offer to place such child in a family home or for adoption, and this interpretation seems to be carried out in the rules and regulations prescribed by the Commissioners under the Act, Section 5 of the Act is so broad in its terms as to cover any placing or any assistance, including mere advice given by a physician who might know that a child is available for placement or adoption.

Thus, in a very recent case, which terminated in a directed verdict in favor of the doctor involved, because of the failure of the Government to prove actual assistance or arrangement for placement or adoption of a child, the Corporation Counsel took the position that a mere introduction by a physician of a person having a child for adoption to persons seeking to adopt a child, violated Section 5 of the Act, and rendered such doctor liable for the criminal penalties imposed under Section 8 of the Act. This

case illustrates the inherent dangers to the physician as well as others, and seems to require that physicians exercise care not to assist or arrange in any way for the placing of a child in either a family home or for adoption until the Court of Appeals for this jurisdiction has construed the Act to mean otherwise.

An effort should be made to have the Commissioners, as early as possible, enact further rules and regulations under the Act, specifically defining what constitutes assisting and placement as used in Section 5 of the Act, in order that physicians and others may know whether or

not they may give advice concerning a prospective adoption or placement, or whether they may inform others that a particular child is available for placement or adoption. Until such regulations are adopted or until the Act and the regulations are construed by the Court of Appeals, any person giving advice is placed in jeopardy of being tried criminally under the Act, on the theory that by doing so he has violated Section 5.

WARREN E. MAGEE
*Counsel for The Medical
Society of the District of Columbia*

VOLUNTARY ADMISSIONS

The physician in private practice whose patient needs care in a hospital makes arrangements with the family and hospital and sends him there without formality. If a patient is found unconscious in the street he is sent to the hospital without his consent. However, if a patient is suffering from mental disorder a complicated chain of legal proceedings must be set in motion if he is to be under care for more than an emergency period—provided, that is, that he lives in the District of Columbia or one of a few states.

To be sure, a patient who feels the need of psychiatric attention may request that he be admitted to Gallinger Hospital, but if his care at Saint Elizabeths Hospital is contemplated, a complaint must be filed, he must be served with a summons to appear at a formal session of the Commission on Mental Health, where witnesses will be summoned to appear against him, and he must be adjudicated to be an insane person, dangerous to himself or others, and “indigent” to boot, deprived of even the right to endorse a check. (If he lived in a state, a similar proceeding would deprive him of the right to vote, but here at least one cannot be deprived of that which he has not!)

The result of such proceedings is to deter persons in the incipient stages of mental disorder (the most curable period) from seeking institutional care, even though that is clearly indicated. Delay in such a case may easily result in suicide or in the conditions advancing to a degree which may render it more refractory to treatment. Many mental patients recognize that they are ill, at least early in their difficulty, and would readily seek aid if judicial commitment were not required. In about two-thirds of the states it is permitted that a person who feels the need of mental hospital care and is mentally competent to make such application may be admitted on his own request and allowed to leave on written notice of a specified length. The practice is thoroughly sound, and has worked well. Obviously, ability to pay should not be a prerequisite for such application.

It is gratifying to note that the Society has officially endorsed this progressive step, and that suitable legislation will shortly be submitted to the Congress for its consideration. The Nation's Capital should not lag in modern legislative provision for its mentally ill.

W. O.

In and Out of Focus

BY THE OBSERVER

Research of the Future

Although research has been stimulated by the war, prior to the conflict it was less highly regarded, according to Dr. John R. Williams, who delivered the Banting Memorial Lecture before the Faculty of Medicine of the University of Toronto last year. The fact is, he said, that the United States, with all its wealth, expends only 0.6 per cent of its total income for research, as compared with the Soviet Union's 0.8 per cent and Great Britain's 0.1 per cent.

Devoting his attention to the present status of scientific knowledge and what may lie in the future, Dr. Williams states:

"Everyone is familiar with the great improvement in public health which has taken place in the last fifty years. The eradication or control of the communicable diseases of childhood and the water and milk-borne infections accounts

for most of the gain. However, there remains a large number of so-called degenerative diseases which are still largely unsolved. These include cancer, the cardio-vascular-renal diseases, and the disorders of the endocrine glands. Mortality statistics do not reveal the true picture because there is a vast amount of disabling but nonfatal illness. These noninfectious diseases, which today are the chief causes of death and against which we have made little progress, offer an unlimited field for medical research.

"How should this task be approached? At the present time, a large part of medical budgets is expended in treating afflicted patients, a considerable portion is spent in clinical research which consists in observing and classifying the passing phenomena of the disease, a sort of factual or statistical compilation which may or may

not contribute to the elucidation of the underlying principles involved. According to Sir Frederick Hopkins, this type of research is greatly overrated as a scientific procedure. He believes that, if progress is to be made, the emphasis should be placed on pure research and in the newer fields of science, namely biophysics and biochemistry. He goes on to say that descriptive and morphological studies of disease structures serve mainly for purposes of classification and that studies of function

and the endeavor to correlate this with structure, too, have limited usefulness. We must go far beyond these stages of investigation, however, and look beneath the surface of the cell and think in terms of molecular events. He postulates that, in the future, disease will be viewed from a new standpoint and that even now those who think in terms of molecular events may have visions of progress denied to those whose thought is guided by the visible alone.

"We are now entering a new era in which it is to be hoped that scientific research, including that which has to do with medicine,

will be the main function of the worker who will possess the requisite preliminary training and will be afforded the facilities for continuing progress. In such a program, pure or abstract research, the study of principles, will play a much larger part than it now does, and less attention will be paid to the so-called practical studies, the gathering of ever changing facts.

"Research of the future, to be effective and useful, should be planned as a long range project to be undertaken only by those with the proper training who are willing to dedicate years of their lives to efforts which may prove to be fruitless. It, of course, must be well conceived and well supported. We should encourage those who are best fitted for the purely scientific work, and we should also try to bring the practical results of science into the lives of our people. We should teach

WHO IS THE OBSERVER?

Several readers of this column have inquired about the identity of the person responsible for this column. Some have taken for granted that I am the Observer. There has been no desire to maintain secrecy in this matter. In fact, those who have inquired have been informed that the *Medical Annals'* Managing Editor, Theodore Wiprud, is the Observer.

Mr. Wiprud formerly conducted a column in the *Annals* entitled "Pertinent Paragraphs" which in July 1943 became "In and Out of Focus." He has contributed many articles to medical journals and is the author of "The Business Side of Medical Practice."

Naturally I am pleased that this column has been favorably received not only in Washington but throughout the country.

Wallace M. Yater, M.D.
Editor

them to think objectively in terms of science and, as we succeed in so doing, fads and 'isms' will disappear. Everyone should know as much about science as possible as it affects him individually.

"The physician in such a plan would serve a dual function. He might serve as a sort of assistant to the pure scientist, observing and recording phenomena in his daily practice; secondly, acting as an interpreter of science to the public at large. Many schemes for the improvement of medical care have been proposed under the name of socialized medicine, but I am confident that that one which promotes the extension of research and provides for its broadest application not only will be the wisest, but it also will be the plan most likely to succeed. The valuable part the general physician can play is well illustrated by the life of Sir James Mackenzie, who devoted most of his life to general practice in the country, but who by self-training became an accomplished scientist."

Calling upon the medical schools to stimulate the interest of their students in research, Dr. Williams says:

"It is the task of the university, the medical school, and the medical profession to raise the standards of medical practice and to conquer or solve the several dreadful maladies which impose such a burden on humanity..."

"...Research as a permanent career for young men should be provided and encouraged. Next, the value of such research should be carried to the people in a never ceasing program. The scientist should be willing to come down from his ivory tower, unbend, and discuss his work with the common folk because they make up the bulk of the population and pay most of the taxes. An idea or an institution can have no greater stimulus or support than the interest of the common people. The practising physician should enjoy the confidence and give such assistance as may be possible to the research movement. He should be the scientific interpreter to the public. His affiliation with a university research activity would add dignity to his stature and breadth to his training. He would be more of a thinker and less of a dispensing clerk. This education of the public and the doctor in the significance of research would also have its value in gaining the support of politicians or officials in charge of the appropriation of funds. One cannot expect enthusiastic financial aid from administrative officials for the support of a nebulous project of which they know nothing and in which they have no interest."

A Challenge to Private Practitioners

One cannot help but be impressed by the unanimity of opinion among state medical leaders with regard to the course which organized medicine should pursue. With few exceptions, those with whom your Observer has talked agree that the medical profession must offer a satisfactory program if the control of medical practice is to remain in the hands of physicians.

On October 2, 1944, Dr. Linwood D. Keyser, President of the Roanoke Academy of Medicine, Roanoke, Virginia, gave emphasis to this conclusion in an address before the Academy:

"We live in a world of flux, our civilization is being recast, and we see the old order evolving into something new which, whether better or worse, will certainly be different. Biology teaches us as one of its fundamental principles that any species which does not adapt itself to changing conditions will definitely, sooner or later, cease to exist and become extinct. Political and sociologic systems over the ages have likewise followed this law. In our own generation we have seen the practice of medicine change in the locale of its activity from the bedside at the patient's home to the laboratory, to the well equipped office, to the organized clinic, and above all to the modern well-developed hospital. We have individually and severally adapted ourselves to this change and medicine has progressed.

"Now the environment changes again, and rather quickly too, and a new set of conditions confront us. We are at war. The exigencies of the moment are met with extra, and often exhausting effort. With lack of colleagues, nurses, house staffs, technicians, orderlies and domestics, without complaint we should and we do carry on. Yet as average doctors in an average American community we cannot be blind to certain challenges that the new order of the postwar world will shortly bring. The development of medical centers supplied by State and Federal agencies or foundations, the activity of many industries in affording medical care to employees and their families, the encroachment of public health agencies upon certain phases of medical practice, the regimentation of doctors in the armed forces, the growing resentment of the public to the so-called high cost of medical care by private physicians when fees for laboratory and specialist consultations become pyramided to an unseemly figure; these things are already with us. As we look ahead to those days when peace shall come again,

these innovations in our system of medical practice will, whether we like it or not, be further developed and constitute a challenge to certain ideals which we in America have long held sacred."

Dr. Keyser says that the freedom of the individual to choose his physician "comes almost next to his right to choose his religion." But he queries: "Can we meet the demands of our modern social evolution and maintain this time honored right of choice of physician?" He answers this question: "Yes, I believe we can, but not without strong effort and coördinated and coöperative planning. As you know, I am not an economist nor an organizer; neither am I presumptuous enough to propose a specific plan. However, I am keenly aware of one fact. If the organized medical profession does not act, State and Federal agencies will do so."

What type of program would Dr. Keyser offer?

"Any program," he says, "which the medical profession may present should be devised by representatives of this profession through its recognized agency, the American Medical Association, this in coördination with governmental agencies. Coöperative committees from these bodies could make a survey of local and state needs for medical care. Certain centers could have local, state or governmental hospitals supported in part or in whole by government aid. Staff appointments to such institutions could be made from licensed practitioners, their specialty and consultant ratings being determined in accordance with standards prescribed by the American Medical Association and its affiliated societies or certifying boards. The patient should have his choice of doctor, within the limits of this physician's qualifications as a practitioner or specialist. Insurance compensation should be accepted as total or partial payment for professional services as determined by local society action or by agreement between the patient and physician. The physician should continue to have the right to refer his patients to colleagues of their mutual choice for consultation. Physicians and not political agencies should have predominant influence in making appointments of medical personnel in the organization of staffs of hospitals and clinics. In the hands of the physician should continue to rest matters of regulation of practice and of discipline when necessary."

Much of what Dr. Keyser has to say is not new. His remarks, however, do point to the

fact that there is a growing feeling among medical leaders everywhere that the big task ahead of the medical profession is a constructive one. The days of rear guard action are over.



Doctors as Patients

Doctors, if we are to believe usually reliable sources, are not the best patients. They are inclined to fuss about minor discomforts and in general be pretty demanding. The explanation, perhaps, lies in the fact that the doctor knows too much for his own good. Every symptom and every clinical sign has far more meaning to him than for the layman. In fact, he is likely to exaggerate their true significance. If he is the worrying kind he steadily deteriorates as a patient. If he is wise, he soon learns patience and eventually he appreciates what it means to be on the receiving end of medical care.

In describing how it feels to be a patient, Dr. T. C. Davison has written a highly interesting and informative article for the April issue of *The Journal of the Medical Association of Georgia*. After reading what he has to say one can come to only one conclusion: Here is a doctor with patience and understanding who has profited by his experience.

"When, after a hard day's work," Dr. Davidson writes, "one suddenly finds himself sitting on the side of his bed with pain under the sternum, and extending down his left arm, and has some difficulty in getting a deep breath or has air hunger, and these symptoms do not respond to the remedies at hand but require a hypodermic, and these attacks recur at 24-hour intervals for several days, one realizes that he has ceased to be the doctor and has suddenly become the patient. Everything is in reverse; instead of giving orders he is now taking them.

"The electrocardiogram reports are in, consultation is held and the verdict is: occlusion of a small branch of the coronary artery. Well, we should be thankful for *small* favors, yes thankful that they are no larger, and especially since several of my personal friends have suddenly passed on recently because of coronary occlusion.

"Now, comes the sentence: five or six weeks in bed,

several more weeks out of normal work and habits, and then work half-time for one year."

Evidently the "sentence" did not floor the good doctor, for he goes on to say: "Many times I have felt like spending a week in bed, but after a few days there the routine became rather monotonous. I probably shed a few silent tears in self-pity and then set about rearranging my daily schedule. For many months I had been getting up at six o'clock each morning, which is rather early in the winter time, and would be at the hospital by 'sun up'; and didn't get home until dark or later, and frequently was called out at night.

"I now have had a chance to really get acquainted with my family and to appreciate them more."

Slowly Dr. Davison improved, and about the last lap he says:

"Being just up from several weeks illness and now convalescing, I have had considerable time on my hands to think things over. I have tried to be a good patient and obey the instructions of the doctors and the nurses, and have tried not to make suggestions. At first, while really ill, that was fairly easy; then came the weeks of just remaining in bed or serving out my sentence. One finds it hard to pass away the time, but gradually one learns to regulate his time schedule, beginning early in the morning by listening to the World News over the radio; breakfast is served while you listen to the breakfast clubs over radio, followed by reading the morning paper, then spending several hours reading the many books which friends have brought in, such as 'The Emperor's Physician,' 'The Doctors Mayo,' 'The Autobiography of Irvin Cobb,' 'Canal Town' and others. Lunch is served, more reading, then comes the afternoon news by radio and the evening paper, then dinner and more reading, and finally the late news at 10:00 p.m. and lights out for the night.

"I would watch through the east window for the sun to come up in the morning, then in the late afternoon gaze out the west window of my room as it dropped down behind the pine trees in the west, and the stars began to sprinkle the heavens. On one such day I was reminded of my good friend Dr. H., who several years ago, after being dangerously ill for weeks, finally began to improve and, just after the big ice storm we had at that time, he was shuffling down the corridor of the hospital on a

beautiful sunlighted day, when one of the interns passed him and said: 'It's a beautiful day, Dr. H.' My friend stopped and pointed his palsied finger at him and said: 'Listen son, they are all beautiful to me.'

"When first allowed out of bed I would sit by the window and read and watch as the season slowly changed. The rains came, followed by sunshine, now the jonquils, daffodils, and narcissus are in bloom, the weeping willows down by the creek are budding rapidly, the red birds are singing in the dogwood on the lawn, and the white ducks are swimming in the little pond above the bridge. Winter has given way to spring in the few weeks I have been confined to my bedroom. Now I am allowed to walk outside on warm sunny days; the sun feels good and I just sit on the rocks down by the creek and soak up the sunshine. I am gradually regaining my strength, although I am still a little weak and shaky but feeling fine."

"Now after eight weeks there is a little matter of unfinished business awaiting me; yes, patients."

Who will doubt that Dr. Davison will henceforth be a better doctor. He suffered a severe blow but it had its compensations.



The Gay Nineties

Last month your Observer reported that Dr. Charles H. Stowell, Editor of *The National Medical Review*, published in Washington a half century ago, conducted a column which he called "The Editor's Table." It was very similar to this one except that Dr. Stowell at times strayed far from the medical field. Generally speaking, however, he stayed within bounds.

Although problems which he discussed still plague the medical profession, the "Gay Nineties" were in many respects vastly different from the turbulent 1940's. For example, Dr. Stowell was much perturbed by the devil-may-care speedsters of his time. Writing under the caption "The Wheel! The Wheel!" he said:

"We do not believe any but the extreme devotee believes that the present craze for a wheel will long continue. That the wheel has come to stay, none dispute; but who can believe that every one is to remain excited over a method of locomotion which makes enthusiastic riders maintain for hours a most unnatural and injurious position of the body? Did the society for the Prevention

of Cruelty of Animals think one-half as much of members of the human race, as they appear to think of old dogs, sick cats and street car horses, they would see to it that many of the evils of cycling be corrected. If the riders will maintain anything like the position which nature intended the human form to take; and if racing be elevated from the present exhibitions of brute force, then some of the objections will be removed. At present, one only has to be willing to look in order to see all kinds of deformed creatures flying through the streets without the slightest regard to the safety of others. To all lovers of the wheel we would suggest that they make an honest effort to correct these evils before this most valuable exercise be brought into disrepute."

What Dr. Stowell would have said if anyone had suggested to him that in 1945 "the wheel" was still a mode of locomotion, but only for those who had no other means of transportation or who enjoyed a leisurely "bike" ride, is interesting to speculate. What he would have said had someone told him that man would fly through the air at a speed of 400 miles an hour, travel in a "horseless carriage" at 70 or more miles an hour, and that the human voice would be carried to the far ends of the earth on air waves, one can only conjecture.

The 1940's have nothing in common with the nineties where propriety is concerned, either. Dr. Stowell looked none too favorably upon what was considered respectable in the Victorian period. The following is from an item, "In Unlettered Wagons":

"Street car advertising evidently pays; at least the advertisements are read. A certain brewing company of this city thus advertises its beer. On the card is the following: 'Families supplied in unlettered wagons.' The philosopher must pause to consider why it is necessary to add this sentence. Our groceries, dry goods and fuel are delivered in wagons plainly lettered, setting forth the character of the contents and the name of the dealer; but in the case of beer, families are supplied 'in unlettered wagons'! Is it a confession that the business is one which must be conducted in secret in order to receive the support of families?"

Of course Dr. Stowell in his wildest imaginings never dreamt of the cocktail bars of our day being frequented as much by women as by men.

How shocked he would have been had he been transported to the twentieth century and witnessed some of the best of our femininity elbowing male customers in a bar. (To him it would still be a saloon.)

Perhaps Dr. Stowell was lucky.



Over-the-Counter Sale of Sulfa Drugs

The Society's Committee on Public Health, of which Dr. Edward J. Stieglitz is Chairman, recently called upon the District Health Officer to curb over-the-counter sale of all sulfonamide drugs in the District of Columbia. If necessary, the Committee urged District Commissioners be requested to assist him in effecting such restrictions. The Committee endorsed the recommendations contained in the following report of the Subcommittee of the Committee on Public Health Relations of the New York Academy of Medicine, pointing out the dangers inherent in the use of the sulfonamide drugs.

"SECTION 118 of the Sanitary Code of the City of New York prohibits the sale of sulfonamide drugs, whether for internal or external use, without a prescription. Two groups of sulfonamide preparations are excepted, namely, sulfonamide nose drops containing not more than 2.5 per cent of sulfa drugs and adhesive bandages containing sulfathiazole. (The usual concentration of the drug in these bandages is 6 to 12 mg. of sulfathiazole per inch of bandage.) These two exceptions have been allowed because (1) the Federal Food and Drug Administration permits the over-the-counter sale of these products, provided they bear proper precautionary labels and directions for use, and (2) at the time this ruling was made there was no actual proof that the external use of the sulfa drugs in small concentrations had caused any harm.

"For advertising reasons sulfa drugs are now being added to various kinds of salves, tape bandages, shaving creams and similar products which are sold under well-established proprietary names. Of late, one of the drug concerns applied to the Health Department for permission to sell without prescription a suspension containing 5 per cent of sulfathiazole. In view of this and in view of the fact that more and more reports appear in the literature to the effect that topical application of the

sulfa drugs can arouse a hypersensitivity resembling an allergic phenomenon, the Commissioner of Health submitted to the committee the question of what action the Board of Health should take in this regard.

"After looking into the matter carefully, your subcommittee has come to the conclusion that clinical experience bears out the fact that a small percentage of people become sensitized to the sulfonamide drugs, that a severe systemic reaction may be produced in these persons when the drugs are administered a second time and that a minute amount of the sulfonamide drugs applied to the unbroken skin or to the mucous membranes can and does sensitize an individual even more quickly and with greater certainty than when such drugs are administered by mouth.

"Because such sensitization is often dangerous and prevents the use of the sulfonamide drugs in treatment of conditions in which they are particularly indicated, because over-the-counter sale of preparations containing sulfonamides will expose many persons to the danger of sensitization, and because the wide use of the sulfonamide drugs in effective concentrations may result in an increase in organisms resistant to the sulfonamides, your subcommittee recommends that, until such time as clinical evidence may justify a contrary course in action, Section 118 of the Sanitary Code of the City of New York be so amended as to eliminate all exceptions from the clause which prohibits the over-the-counter sale of sulfonamide preparations.

"The subcommittee wishes to suggest the desirability of making this recommendation known to the general public. The subcommittee likewise considers it desirable to issue a statement on the part of the Committee on Public Health Relations to the general profession warning against the unnecessary use of sulfonamide preparations for the treatment of minor conditions."

It is to be hoped that action on the Committee's recommendation which, by the way, was endorsed by the Executive Board, will soon be taken.



Labor's Power Underrated? Doctors in Michigan don't do things by halves. This is shown by the enthusiasm with which they have supported various experiments in medical care and their efforts to cope with controversial issues. One of the fruits of their enterprise, Michigan Medical Service, is one of the most successful prepayment

medical service plans in the country. Despite accomplishments to their credit, they were recently warned that many difficulties lie ahead.

Some months ago John F. Hunt, public relations counsel, addressed the Annual County Secretaries' Conference of the Michigan State Medical Society at Detroit on the subject, "Will Free Enterprise Survive in Medicine?" The gist of his message was that the medical profession must offer a constructive program, one which will meet the health needs of the nation, and that the Michigan medical profession should not only bring its influence to bear in its own state but throughout the nation.

The portion of Mr. Hunt's address which held special interest for your Observer follows:

"...if there is anyone in your profession who still is of the opinion that labor speaks in a small voice, I would like to give you just a couple of figures. Fairly accurate sources give the CIO between five and six million members. The same sources estimate the AF of L membership between six and seven million. If you take the low figure in each case you have a total of 11 million individual labor votes. I doubt if there is anyone naïve enough to even hope that each labor member would not vote his complete family as a unit on a question of this kind. But to be conservative, let's just say that each labor membership represents only two family votes. You have then a total of 22 million individuals who have told you in unmistakable terms that they are in favor of government-controlled medicine and hospitalization if you don't provide them with the kind of health security which they demand.

"In order to more simply indicate the strength of this pressure, let me remind you that in the last election there were approximately 49 million votes cast. Twenty-six million of these returned the New Deal to the White House. Need I remind you that the proponents of the New Deal have a pretty good record of getting the things they want and go after?"

Mr. Hunt's address was made before President Roosevelt's death. Whether he would now express himself differently with regard to the potency of the New Deal is a matter for speculation. In your Observer's opinion, labor will have much to do with shaping the future of medical care regardless of the fortunes of political parties.

*Wagner
on Health
Insurance*

Until quite recently official publications of medical societies have been reluctant to publish views on socioeconomics contrary to those held by themselves or their friends. This ostrich-like behavior is difficult to understand. Certainly physicians are not so easily influenced that it is unsafe to publish opinions of those on the other side of the controversy.

The *Wisconsin Medical Journal* should be commended for presenting the views of Senator Robert F. Wagner of New York on health insurance. As every doctor knows, the Senator is one of the authors of the Wagner-Murray-Dingell Bill.

Here is what Senator Wagner had to say to the Wisconsin physicians:

"Propagandists against health insurance shout 'regimentation' of doctors and patients, 'political' and 'socialized' medicine, 'lowered standards,' and so on. But health insurance is *not* socialized medicine. Health insurance is simply a method of paying medical costs in advance. It is simply a method of assuring a person adequate medical care by eliminating the financial barrier which exists between the patient and the doctor.

"The legislation which I have introduced on health insurance assures free choice of physician and patient—free choice to participate in the system, or to obtain medical care outside the system; and free choice on the part of physicians as to methods of remuneration. High standards of medical care are protected and encouraged through incentives for the professional advancement of doctors, postgraduate study, professional education, research, and the availability of consultant and specialist services, laboratory benefits and X-rays to all, regardless of ability to pay.

"There are many individuals, honest and sincere in their desire for improved conditions, who nevertheless fear any change and distrust all new social legislation. Wisconsin has justly earned its reputation as a pioneer state in social legislation. Your state faced similar opposition against many reforms for social betterment, but you have persevered and succeeded to see other states follow where you have pioneered. Wisconsin can also take credit for passing the first state unemployment insurance act. Wisconsin was the first state where workmen's compensation became effective. Now all the states but one have workmen's compensation laws, and all include medical benefits. This is health insurance for

industrial accidents and disease. All I propose is that we extend the principle of health insurance to cover non-industrial accidents and diseases."

We hope the doctors of Wisconsin had their guard up when they read what Senator Wagner had to say about their state. A little flattery sometimes goes a long way.



*A Change for
the Better*

There are many of us who have felt that the American Medical Association would have been greatly strengthened had it kept in closer touch with its constituent and component societies. The present relationship is for the most part a very impersonal one. Generally speaking, officers and members of these societies know little about the national organization except what they read. Infrequently they may see or hear one of its officials. But personal contact, which would cement loyalties, has been missing.

At the present moment the Association appears to be endeavoring to make amends. In fact, so diligent has it become it now suffers from what might be called "bulletinitis." Across your Observer's desk have come bulletins on somewhat similar subjects from three different sources within the Association. The one which has been in existence the longest is issued by the Bureau of Legal Medicine and Legislation. The Bureau devotes itself to the analysis of bills before the Congress. Then there is the bulletin prepared by Dr. Joseph Lawrence, Executive Director of the Council of Medical Service and Public Relations, situated in Washington. Dr. Lawrence also confines himself largely to legislation. Being on the ground, he makes some interesting firsthand observations. The Council issues another bulletin from its Chicago office which, your Observer is told, is authored by Thomas H. Hendricks, Secretary of that body. This bulletin concerns itself with legislation, too, although much of the material is devoted to medical economics. Finally the youngest of the Association's bulletins is issued by the Board

of Trustees of the Association. It contains comments on social and economic trends and views approved by its sponsors on legislation.

Appreciative as recipients of these bulletins are for the interest now shown in them, it would seem that this is overdoing it a bit. The Association might well consolidate the bulletins. There should be no more than two—one devoted to legislation and the other to socioeconomics.

As to the manner in which the material is now presented, all four bulletins have merits. Restraint is very noticeable in one, only views which are approved are presented in another. There is a lack of objectivity that is at times disconcerting. On the whole, however, a good job is being done.

Leaving the bulletins for a moment, there is the all-important matter of personal contacts with constituent and component societies by officials of the Association. These are being made to some extent by the President, the Secretary and the Editor of the *Journal of the American Medical Association*. The real need, it would seem, is for a field secretary. This is not a new idea by any means. In fact it was contemplated years ago by the Association. It has a part-time one now in the person of Dr. Lawrence. But his work is such that he cannot remain in the field continuously. There is no substitute for the personal touch, a fact that the Association should no longer ignore.

What all this amounts to is that the Association has made a beginning, although a not particularly well organized one. It should proceed to remedy this situation and develop a sound professional relations program. The result, your Observer believes, would be gratifying to all concerned.



*"Tell Me
About the
Roses!"*

The war has emphasized the fact that it is the little things that enrich or mar our lives.

Usually we meet major crises with fortitude. But minor irritations may

set in motion emotional reactions which color our whole existence. On the other hand, the simplest forms of relaxation often add much to the joy of living. One man finds contentment in his study where he spends many a quiet evening reading a good book and taking his ease. Another enjoys his garden. Many find their greatest pleasure in tinkering with gadgets. If in addition to these pursuits there is freedom to do much as one likes, and a congenial home atmosphere, the world seems a pretty good place.

It has taken a war to bring home to millions of our fighting men how precious are the things which Americans take for granted. Throughout the world they have seen poverty beyond description, regimented peoples who have little or no opportunity to do what they like and fear which begets despair. Your Observer recalls vividly how stirred he was when he witnessed a motion picture showing the landing of our wounded at an East Coast port, how one seriously injured G. I. on a stretcher, when placed on the ground, fondly patted the earth. Here was home and all the things it stood for—the so-called little things that make life worth living.

A few weeks ago a Naval medical officer recently returned from Iwo Jima visited your Observer's office. He talked at length about conditions in the Pacific. He said very few Americans will ever appreciate how much letters mean to our soldiers and sailors in distant places. Even those who do, he explained, do not write about the things which are nearest to the hearts of our fighting men. There was no need to write them about current events, he pointed out, for they read the same publications we do. What they wanted was to be told about home, the condition of the family car, and what their folks were doing to enjoy themselves. He said he was a garden enthusiast, and while he was in the Pacific he had written his wife, "Tell me about the roses!" He dreamed often of his garden at home. Had it been well cared for? Were the roses in bloom? If only he could tend

to them for one day—yes, for one hour. It would be grand.

If your Observer has learned anything in these tumultuous years, it is this: It is a great privilege to be an American. How deeply the doctors in the armed forces on all fronts feel on this point is shown time and again by their letters. They would not trade a square foot of home for all the rest of the world.

We live in a good land, but we have it within our power to make it a better one. How? By demonstrating in our daily lives that we really appreciate being Americans.



*Let's Have
the Facts*

Your Observer has listened to innumerable heated discussions on compulsory health or sickness insurance in which both physicians and laymen participated. More often than not physicians came off second best for the reason that they were not well informed. It seemed sufficient to most of them that the medical profession is opposed to outside control. A few, of course, gave a good account of themselves, presenting convincing arguments. Others possessed only a smattering of facts, and in a lively discussion soon bogged down.

It was this situation that prompted the *Journal of the Medical Society of New Jersey* to announce that it would publish editorials on "Public Relations and National Sickness Insurance." The *Journal* says: "More and more people are becoming interested in, and asking more questions about, the medical care distribution problem. It is essential that the individual physician be able to answer their questions intelligently, constructively and without arousing a spirit of antagonism against the opinions of the profession."

In its April issue the *Journal* propounds these questions: Why would a compulsory sickness insurance system not be as effective as our educational system which is paid for by taxation? What is medical care?

In regard to the first question, the *Journal* points out that in debate physicians are often embarrassed by having unintentionally given the impression that they are opposed to the present educational system. Advocates of compulsory sickness insurance stress the parallel between it and this system. The fact is they have little in common because education is applied to normal persons. Medical care, it is stated, is applicable to abnormal or sick persons and then only on an individual basis in accordance with the needs of the individual rather than of a group.

Concerning the question of medical care, the *Journal* emphasizes the fact that too much stress has been placed on the technical character of such service, such as X-rays, metabolic tests, electrocardiograms and a multitude of laboratory procedures. "They [those who favor compulsory health insurance] fail to appreciate that such services are purely adjuncts to good medical care, applicable only to a minority of sick persons, and that the value of such services is limited by the qualifications of the physician who interprets them."

These points are well taken. In future issues the *Journal* will undoubtedly have much more to say on these subjects. If doctors would read these and other comments they would be in a position to discuss compulsory sickness insurance more intelligently, to offer sound arguments, and not have to rely upon their emotional reactions.



*Philadelphia's
Physicians'
Families
Protected*

Any physician who has been engaged in practice in a community for a period of years recalls colleagues who died leaving their families with little or no means of sustenance. Their failure often had sad consequences. Why did they fail their loved ones? Perhaps they fully intended to make proper provisions for them but never got

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SOCIETY HONORS MAJOR GENERAL IRELAND

One of the memorable events of the year was a program presented by the Medical Society of the District of Columbia on April 18 in honor of Major General Merritte W. Ireland, Medical Corps, United States Army, Retired, Surgeon General of the Army from 1918 to 1931.

In the course of the program General Ireland was presented with a citation by the Society "in recognition of his distinguished service to humanity and his outstanding contributions to military medicine."

General Ireland, who is an Honorary Member of the Medical Society, has seen forty years of active service in the Army Medical Corps. As Chief Surgeon to the American Expeditionary Forces in World War I, he was commended by General John J. Pershing for keeping manpower and morale at a high peak of efficiency, particularly through the prevention of venereal diseases, justifying General Pershing's pride in commanding overseas and bringing back to America "the cleanest Army in the world." For his outstanding record he was given the Distinguished Service Medal.

Perhaps the most noteworthy achievements during his tenure of office as Surgeon General of the Army were the development of an educational system in the Medical Department, the improvement of Army hospital facilities, and the reorganization of the Surgeon General's office so as to utilize the experience gained during World War I. The greatly improved care of the wounded in World War II, in-

cluding early treatment of battle-injured men, and their swift evacuation to Army bases, has been due in considerable measure to the education of members of the medical service in the Field Service School at Carlisle Barracks, Pennsylvania. General Ireland was also largely responsible for improved methods of

training medical officers in subjects peculiar to the Army requirements at the Army Medical Center.

These and many other contributions to General Ireland's credit were reviewed by the speakers of the evening, Major General Norman T. Kirk, The Surgeon General, United States Army; Thomas Parran, The Surgeon General, United States Public Health Service; and Rear Admiral J. C. Agnew, Deputy Surgeon General, United States Navy.

Presiding at the meeting was Dr. William M. Ballinger, Acting President of the Medical Society of the District



MAJOR GENERAL MERRITTE W. IRELAND, M.C., U.S.A., RETIRED

of Columbia.

Martial music for the occasion was provided by the 304th Army Service Forces Band, Chief Warrant Officer John S. Martin conducting.

At the conclusion of the speaking portion of the program, motion pictures of the Army Medical Corps in World War II were shown.

A buffet supper was served, during which the string trio from the 304th Army Service Forces Band presented several musical selections.

Distinguished guests to whom invitations had been extended, many of whom were present, were: The Honorable Elbert D. Thomas, Chairman of the

Committee on Military Affairs, United States Senate; The Honorable Andrew J. May, Chairman of the Committee on Military Affairs, House of Representatives; Vice Admiral Ross T. McIntire, The Surgeon General, U. S. Navy; Thomas Parran, The Surgeon General, U. S. Public Health Service; Major General Norman T. Kirk, The Surgeon General, U. S. Army; The Honorable Guy Mason, Commissioner, District of Columbia; Rear Admiral Edward R. Stitt, Surgeon General, U. S. Navy, Retired; Hugh S. Cumming, Surgeon General, U. S. Public Health Service, Retired; Rear Admiral Percival R. Rossiter, Surgeon General, U. S. Navy, Retired; Major General James Carre Magee, Surgeon General, U. S. Army, Retired; Rear Admiral H. W. Smith, Medical Corps, U. S. Navy, Retired; Rear Admiral William Chambers, Medical Corps, U. S. Navy; Major General Shelley U. Marietta, Medical Corps, U. S. Army; Major General David N. W. Grant, The Air Surgeon, Army Air Forces; Major General George F. Lull, Deputy Surgeon General, U. S. Army; Rear Admiral

J. C. Agnew, Medical Corps, U. S. Navy; Rear Admiral John Harper, Medical Corps, U. S. Navy; Brigadier General James Stevens Simmons, Medical Corps, U. S. Army; Brigadier General Raymond W. Bliss, Assistant Surgeon General, U. S. Army; Brigadier General Frank T. Hines, Medical Corps, U. S. Army; Brigadier General Stanhope Bayne-Jones, Medical Corps, U. S. Army, Retired; Colonel William L. Keller, Medical Corps, U. S. Army, Retired; Colonel Albert G. Love, Medical Corps, U. S. Army; Colonel Augustus Thorndike, Medical Corps, U. S. Army; Colonel James R. Hudnall, Medical Corps, U. S. Army; and Colonel John C. O'Laughlin, U. S. Army.

The Committee on Arrangements were: James W. Watts, M.D., *Chairman*; Major Henry B. Gwynn, M.C., A.U.S.; Paul F. Dickens, M.D.; James A. Gannon, M.D.; Comdr. Howard F. Kane, M.C., U.S.N.R.; A. Magruder MacDonald, M.D.; K. Elizabeth Parker, M.D.; and Theodore Wiprud, *Secretary*.

PLACEMENT OF CHILDREN IN ADOPTION

A. PATRICIA MORSS

Chief, Child Welfare Service, the Board of Public Welfare of the District of Columbia

Many Washington doctors concerned about the placing of babies are asking for explanation of Public Law 292, an Act to Regulate the Placing of Children in Family Homes, more popularly known as the Baby Broker Act. They ask, "Why is the law necessary, how far can we go in the placement process, and what resources exist in Washington for the placing of babies?"

Early adoption laws were intended only to provide evidence of legal transfer of the child by the natural parents to the adopting parents and to provide for a public record of the transfer similar to the registration of a deed. With the extension of the work of child welfare societies everywhere it was brought to light that some parents and even some agencies have been willing to have children adopted by unsuitable and unscrupulous persons. To prevent this 38 states and the District of Columbia have enacted legislation to provide the courts hearing adoption cases with the machinery for obtaining social investigations to determine that the family ties of the child are not

unnecessarily broken, that adopting parents are able to meet the new responsibilities and that the child is not unsuitable for adoption. The District of Columbia enacted such legislation in 1938—Public Law 370, an Act to Regulate Proceedings in Adoption.

Experience with our adoption laws indicates that the intent of good adoption laws is nullified if children are not protected by good placement practices. The crux of good or bad adoption comes at the time the child is separating from his own family and goes to the adoption family. The adoption laws providing for social investigation do not operate until a petition is filed. Under most statutes this is not possible until the child has been in the adoption home for a period of six months. The investigation made at this later time may establish facts of such social and legal significance as to present complicated issues for the court and which may only be resolved by decisions which disrupt the plan of the adoptors and the relationships for the child through which he has built up confidence. The investigation may estab-

lish the fact that the parents of a very young mother have learned for the first time of the existence of the infant, desire to care for him and the mother therefore wishes to regain custody; that the father of a child born out of wedlock away on foreign shores on learning of the existence of the child wishes to make provision for his child and to have opportunity to plan with the mother for his future; that a mother given custody of a child by the terms of a divorce decree has placed the child without the knowledge or consent of the father who now opposes the adoption; or that the facts in the mental and physical health histories of one or both of the child's parents, revealed for the first time to the adoptors, make them hesitant to assume the responsibilities.

To regulate placement practices Congress enacted Public Law 292 in April of 1944. The Act and the regulations adopted pursuant to its intent are designed to insure that those who engage in the transfer of the child from his own people to the care of others have the qualifications and resources to determine if it is necessary that he lose his birth rights and his association with his own family, and when it is necessary, that the home suited to his needs will be found for him. The Act leaves to the parents, however, the right to make placement of their own child with persons known to them. Persons and organizations meeting the required standards are licensed by the Commissioners of the District of Columbia to engage in such work.

The application of the Act has been of special value to the child born out of wedlock whose mother, in the belief that speed and secrecy were necessary to protect herself and the child, previously accepted the offers of the commercial agent and the doubtful maternity home as a solution. As the activities of these agents have decreased since the passage of the Act, the unmarried mother has increasingly turned for help to her doctor, who is frequently the first and only person who has knowledge of her problem. The doctor knows also of the keen desire of many patients to adopt children when it has been determined that they are unable to have their own. On first thought there appears to be the opportunity to relieve the problems of both. Most physicians, however, realize that they do not have the time and the resources to deal with the social and legal responsibilities involved and have regarded the legislation restricting such action to special agencies as wise.

The referral of the doctor's patients to child welfare agencies has not always brought results. Patients desiring to adopt children say (1) that social agencies lean in the direction of persuading mothers to keep their babies and few babies therefore ever become available for adoption, and (2) that red tape in the procedures of the agencies means that the few children who are available are one year or more of age before placement is made whereas the adopting parent desires the young infant. The practices of present-day accredited agencies do not necessarily result in such limitations. Agencies will, however, insist on certain safeguards. These safeguards include the following:

1. That the mother be given time to make up her mind about keeping or giving up her child and be given help to keep it if she desires to. If mothers are referred to agencies in early pregnancy and are given the information about alternatives, it is quite possible that at the time the child is born she is ready to make her decision. If a doctor waits to make a referral until the patient is ready to leave the hospital and the mother has not had help to prepare herself for the new situation, the agency would suggest a temporary period of three months before expecting her decision and would provide temporary care of the infant in the meantime if the mother is unable to do so.

2. When adoption seems best the baby's rights will come first. This means an opportunity for a good home where he will be loved and wanted, and where he fits in. The agency files applications from adoptors in the order of application, and makes studies in the order of application, but considers several homes in the sequence in selecting parents which the study of the child and his background and the study of the foster family indicate to be complementary. The trial period in the adoption home is usually six months. Under usual circumstances the child is therefore no older than nine months when the final adoption plan is completed.

3. The identity of adopting and natural parents are never known to each other, thereby avoiding the possibility of subsequent painful meeting for both or the disruption caused by an unstable parent who later changes his mind.

4. Adopting parents have the right to knowledge and are given facts about the baby's antecedents,

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ANNUAL BUSINESS MEETING

Despite heavy demands made upon Washington physicians, there were 125 members present at the Annual Business Meeting of the Medical Society of the District of Columbia held on May 2.

Following the business session, Dr. Joseph S. Lawrence, Executive Director of the Council on Medical Service and Public Relations of the American Medical Association, who is in charge of the Council's Washington office, spoke to the Society on "Public Opinion Will Determine Medicine's Future." Dr. Lawrence's address was well received.

As in previous years, copies of Reports of Officers and Boards and a Review of Committee Activities for 1944-45 had been mailed to the Society's membership so that they would have an opportunity to familiarize themselves with this material before voting on it.

ANNUAL REPORT OF THE CHAIRMAN OF THE EXECUTIVE BOARD

Reminding members that the Society "like all organizations in wartime, . . . has operated with considerable difficulty," the Chairman stated that it had carried on as normally as possible. Included in his report was a résumé of the activities of and actions taken by the Board during the organization year. As copies of the Chairman's report had been placed in the hands of all members, reference will not be made here to specific items.

In concluding his report the Chairman said:

"Much has been said in previous reports about impending changes in medical practice. As revealed in this report, the Committee on Medical Care is busily engaged with plans for the inauguration of a limited prepayment medical service plan and the establishment of diagnostic clinics. It is sincerely hoped that the Committee's proposals will meet with the approval of the Society. Whatever the Society's decision, your officers feel that the Committee will deserve the highest commendation. For its own part, your Board believes that failure to adopt a progressive program would be a serious mistake. The world is moving on and we must move with it."

REPORT OF THE SECRETARY

The Secretary reviewed his activities during the year in considerable detail, with special emphasis on plans to meet postwar problems.

He presented the following membership figures for a five-year period, showing a steady increase in the number of members:

	1941	1942	1943	1944	1945
Active.....	843	855	881	915	931*
Life.....	60	60	64	63	70
Associate.....	208	211	212	204	215*
Honorary.....	7	7	9	9	9
Total.....	1,118	1,133	1,166	1,191	1,225

* On May 1, 1945, 210 Active and 41 Associate members were serving with the armed forces.

In the course of the year the Secretary participated in 154 meetings and conferences. He attended numerous conferences and functions of which there is no record.

He continued to serve as Secretary of the District Procurement and Assignment Committee, giving immediate supervision to the work of the Committee in the Society's office. Among the projects to which he gave considerable time were periodic surveys of practicing physicians in the Washington Metropolitan Area.

The Secretary also continued to serve as a member of the District of Columbia Committee on Nursing.

A new committee of which he is Secretary is the Committee on Service Physicians. This Committee's work will become increasingly important as the war draws to a close.

An acute shortage of gasoline in Washington made it necessary on two occasions for the Secretary to arrange for supplies for physicians. Upon his insistence the Office of Price Administration designated a filling station in the Northwest section of Washington to serve physicians. Two stations had originally been selected, but one owner refused to limit his sales to the medical profession.

One of the controversial issues which arose during the year related to the so-called borderline certificates issued to physicians within the Washington Metropolitan Area by the Maryland Board of Medical Examiners and the Commission on Licensure for the District of Columbia. Over the protest of the Commission the Maryland Board discontinued issuing certificates on November 1, 1944. Citizens, the Commission and the Society joined in urging the Maryland Board to rescind its action, which it did. It agreed to continue borderline certificates for the duration of the war. It was necessary for the Secre-

tary to appear before a legislative committee of the Maryland House of Delegates.

Among his other wartime tasks, and the pleasantest, was writing news letters to the members of the Society in the armed forces.

He also assisted Dr. W. Calhoun Stirling, Chairman of the Medical Division of the District of Columbia War Finance Committee, in the conduct of war loan campaigns.

The Secretary's participation in civic affairs in the community increased considerably during the year. He continued to serve as a member of the Board of Directors of the Council of Social Agencies of the District of Columbia and Vicinity, the Board of Trustees of the Community Chest of Washington, and the Commissioner's Traffic Advisors. Recently he was made a member of the Executive Committee of the Washington Metropolitan Health Council.

Despite handicaps, the 16th ANNUAL SCIENTIFIC ASSEMBLY, held in October 1944, was unusually successful. The Secretary devoted considerable time to this undertaking. As usual, he was in charge of the technical or commercial exhibits, making all arrangements for their presentation. He also assisted in planning other features of the ASSEMBLY.

He coöperated with the Committee on Postgraduate Education, which sponsored a Postgraduate Course in Physical Medicine. Many details had to be attended to in connection with this course, which fell to the lot of the Secretary and his staff.

Members of the Society have been made familiar in previous reports with the duties of the Secretary as Managing Editor of the MEDICAL ANNALS. Mention need only be made that he devotes many days of each month to preparing material for the ANNALS.

One of the most important committees of the Society is the Committee on Medical Care. Under the chairmanship of Dr. Frank B. Costenbader, it has been especially active. During the past year the Chairman and the Secretary made a firsthand study of the Michigan Medical Service. The latter also investigated the operation of the Hospital Savings Association of North Carolina. The Secretary is now assisting with the development of a prepayment medical service plan soon to be submitted for the consideration of the Society membership. He is also giving his attention to diagnostic clinics.

Management of the MEDICAL BUREAU is part of the Secretary's duties. The BUREAU has had its

most successful year. According to the report it had 309 subscribers, 135 to the Telephone Secretarial Service and 174 to the Alternate Listing Service.

Among his other duties were that of group treasurer for physician-subscribers to Group Hospitalization, the membership of which now stands at 421, and the investigation of group health and accident policies, as a result of which the Executive Board and the Society endorsed a policy issued by the Massachusetts Casualty Company of Boston.

In concluding his report, the Secretary expressed his appreciation to officers and members of the Society and the office staff.

ELECTION OF OFFICERS

The voting was heavier this year than last because of the interest which developed in the election. There were 389 votes cast. Members in the armed forces voted by mail. Others, as in previous years, voted at the Society's building from noon until 8:00 p.m. As a result of the balloting, the following officers were elected for the year 1945-46:

President-elect: Dr. William P. Herbst, Jr.

First Vice President: Dr. Fred A. J. Geier

Second Vice President: Dr. Dorothy S. Jaeger

Member of Executive Board: Dr. William M. Ballinger

Delegate to the American Medical Association: Dr. Coursen B. Conklin

Alternate Delegate to the American Medical Association:

Dr. Arch L. Riddick

Member of the Board of Censors: Dr. Harry F. Dowling

Dr. William Earl Clark, who was elected President-elect last year, will take over as President of the Society on July 1, 1945.

As most members know, Lt. Colonel James N. Greear, Jr., this year's President, was ordered overseas several months ago. Upon his departure, Dr. William M. Ballinger was appointed Acting President and will serve in that capacity until Dr. Clark assumes his duties.

REPORT OF THE BOARD OF CENSORS

The Board stated that it had interviewed 48 applicants and that 52 were elected. The discrepancy in these figures is due to the fact that physicians in the armed forces who are not stationed in Washington are not required to make a personal appearance.

This year the Board had specific recommendations

to make to the Society. It stated it wished "to emphasize the desirability of amending the Society's Constitution and By-laws so that applicants will be accepted for a probationary period of one year and be elected by the Executive Board rather than by the Society's membership. The reasons for these suggestions are: (1) that it is difficult to determine in advance the desirability of a physician as a member; and (2) very few members take an interest in the election of new members. In fact, only a small

minority vote on membership applications. This is too serious a matter to be considered in such a haphazard manner. The Board of Censors could well continue to function as a screening body, recommending the acceptance of the physician for a probationary period, the Executive Board taking final action on his application. Your Board hopes that these proposals will be given serious consideration by the Society."

REPORT OF THE EXECUTIVE BOARD*

It was found possible this year to incorporate most of the activities of the Executive Board up to the present moment in the Report of the Chairman of the Board which you received by mail. This report will, therefore, be brief, dealing only with such matters as were not or could not be included.

It is entirely possible that it will be necessary to call a special meeting of the Society before the middle of the summer. There is no certainty about this but your Board hopes if it is found necessary that a large number of our members will make it a point to be present. They can be assured no meeting will be called unless the subject to be discussed is a very important one.

Proposed Amendments to the Constitution and By-laws.—As required by the Society's Constitution and By-laws, the following amendments were proposed in writing at the previous business meeting. They are now submitted to you for a vote.

The first amendment presented for your consideration reads as follows: .

AMENDMENT IX

Section 1. Section 2 of Amendment V of the Constitution and By-laws is hereby amended by adding thereto the following proviso: Provided also that doctors of medicine residing in or having offices in the District of Columbia, representing the American Medical Association and the American Red Cross, may be elected to active membership by the Society.

The purpose of this amendment is to make it pos-

sible to elect physicians representing the American Medical Association and the American Red Cross, whose offices are situated in Washington, to Active membership. At the present time the A. M. A. is represented here by Dr. Joseph S. Lawrence, Executive Director of the Council on Medical Service and Public Relations. Dr. Lawrence is not licensed in the District of Columbia and therefore is not eligible for Active membership. Dr. G. F. McGinnes, Medical Director of the American Red Cross, is in the same situation.

Both of these physicians could, of course, obtain a license in the District by examination. However, there is little point in their doing so because they do not contemplate treating patients. They have both expressed the desire to be full members of the Medical Society and your Board feels that it would be desirable to have such distinguished physicians affiliated with our organization.

Your Board recommends the adoption of this amendment.

The second amendment presented to you for a vote is the following:

AMENDMENT X

Section 1. Article III of Chapter IV of the Constitution and By-laws is repealed as of December 31, 1945.

Section 2. Associate members, commencing January 1, 1946, shall pay ten dollars.

The annual dues for Associate members are at present \$5.00. It is the belief of your Board that there is too great a disparity between the dues of Active members and those of Associate members. Furthermore, physicians who are not eligible for

* Adopted at the Annual Business Meeting of the Society, May 2, 1945.

Active membership because they have their offices and practices in nearby Maryland and Virginia are Associate members and take advantage of many of the benefits the Society has to offer. In view of these facts, your Board recommends the adoption of this admendment.

Appointment of Delegates to the Council of Social Agencies.—As usual at this time of the year, delegates to the Council of Social Agencies of the District of Columbia and Vicinity representing the Society are appointed. Your Board has designated Drs. Henry C. Macatee and William P. Herbst to serve for the coming year and trusts that you will concur.

Health Legislation.—Your Board does not want to go into detail in regard to this subject for the reason that it now appears that scant consideration will be given health legislation by the Congress for the time being. However, the medical profession must not permit itself to be lulled into complacency. As a matter of fact, there are still bills before the Congress which would revolutionize medical practice. And it must be remembered that while the situation is apparently quiescent, sponsors of this legislation are active.

At the present time an intense struggle is going on in the state of California between the medical profession and Governor Warren and the C.I.O. What the outcome will be remains to be seen although it appears quite likely that the type of legislation sought by the Governor and the C.I.O. will not be enacted.

All this activity indicates the trend. The medical profession must not only keep itself informed but assert its leadership in the field of health. This

Society is going forward with plans which will be submitted to the membership before long.

Activities of the Grievance Committee.—The only reason for placing this item on the agenda is to remind you that this Committee has one of the most difficult tasks assigned to any group in the Society. Its work in the past few months deserves the highest commendation. We feel that physicians who come in contact with this Committee have learned that it is very fair in its dealings, not only with the profession but with the public.

A number of complaints have been received in recent months, most of them due to the fact that physicians have not taken the trouble to explain to patients the charges which have been made for services. Had the patients understood, there would have been less difficulty. Of course, in a minority of cases, the situation is such that adjudication is very difficult.

CONCLUSION: It is with regret that we close this report with the announcement that the 17th ANNUAL SCIENTIFIC ASSEMBLY of The Medical Society of the District of Columbia will not be held as scheduled on October 1, 2 and 3, 1945.

A request was made of the Committee on Wartime Conventions of the Office of Defense Transportation that permission be given to hold this meeting because of its nature. However, this request has been denied. The ASSEMBLY for 1945 is therefore cancelled. There may be efforts made to hold a meeting of less pretentious proportions in the Society's building. That remains to be decided by the Committee on Arrangements for the ASSEMBLY. If any plans for a meeting of this kind are decided upon, the membership will be notified.

ANNUAL REPORT OF THE WOMAN'S AUXILIARY

The Woman's Auxiliary to the Medical Society of the District of Columbia has completed a most successful year. Our membership has increased and our meetings have been well attended. We have had one death and two resignations.

We assisted the Medical Society on two occasions by sending out invitations to the Medical Officers' Night during the Sixteenth Annual Scientific Assembly and to the reception, April 18, for Major General Merritte W. Ireland.

We have manned booths for the District Tuberculosis Christmas Seal Sale and the various war bond sales. At the Annual Scientific Assembly we maintained a booth for the benefit of the Medical and Surgical Relief Committee of America.

Our donations to the Community War Fund and Red Cross were substantially increased this year. We also donated funds to the District Tuberculosis Association and the Washington Heart Association.

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War Section

WASHINGTON PHYSICIANS DISTINGUISH THEMSELVES

Lt. Colonel Worth B. Daniels is now Chief of Medical Service at Harmon General Hospital, Longview, Texas, and Lt. Colonel Stuart W. Lippincott is Chief of the Laboratory Division.

Harmon General Hospital has been designated for the treatment of tropical diseases. The only other Army tropical disease center is Moore General Hospital at Swannanoa, N. C. The medical staff of Harmon Hospital has for some time been engaged in a study of relapsing malaria which has resulted in a permanent contribution to the knowledge of the disease. This study is now being extended to other tropical diseases which are rare in this country, such as filariasis, schistosomiasis and dysentery.

Captain Don S. Knowlton is credited with having saved the life of a wounded Marine on Okinawa, May 21, according to an Associated Press report. The Marine was near death from shock after being injured in the explosion of a Jap mine. Two Navy physicians, knowing it might be fatal to evacuate the

wounded man to a hospital 30 miles distant over rock-strewn, rutted roads, telephoned Captain Knowlton, Sixth Marine Division surgeon working near the front lines. A patrol bomber was directed to transport the Marine to a cove near the front and in twenty minutes he was receiving treatment in Captain Knowlton's field hospital.

The following Medical Society members have recently received promotions in rank:

Arnold A. Albert, from Major to Lieutenant Colonel
William H. Beard, from Major to Lieutenant Colonel
Robert H. Detwiler, from Captain to Major

David F. Hodge, from First Lieutenant to Captain
Harvey F. Kreuzberg, from Lieutenant to Lieutenant Commander

Donald H. Leeper, from First Lieutenant to Captain
James M. Loftus, from First Lieutenant to Captain
Leo V. Schneider, from Major to Lieutenant Colonel
Eugene L. Willard, from First Lieutenant to Captain

LETTERS FROM PHYSICIANS IN THE ARMED SERVICES

From Major Philip Litvin, Camp Gordon, Georgia:

My dear Mr. Wiprud: I thought you might be interested in some of the work we are doing here. It has been from one extreme to the other in the neuropsychiatric field for me. If you will recall I was stationed at an anti-aircraft training center in Texas the last time I wrote to you. There we received new recruits and saw them go through their training, in other words tried to do the psychiatric work after they had come to the camp and while they were in training. Now I am with a disciplinary barracks, which means that we have men who have failed to adjust in the Army and have gotten into difficulty and now it is our job to try to salvage as many of them as we can under the circumstances. It is really from one extreme to the other. But the work is a challenge to us and I hope that we will succeed in contributing our mite to the war effort.

If people had the opportunity of seeing the men who come here and could see the pains we are taking in trying to rehabilitate them for either military or civilian life they would be surprised. The illiterates are given an opportunity to at least

learn to read and write and to go further if they show any initiative. Shops have been set up in order to teach various productive occupations to these men who for years never had a trade or job. All in all the attempt is made to better the lot of the man even though he did get into difficulty. Some of the men here with more careful selection during the induction process would certainly not have been accepted. It can only be explained on the basis of the need for manpower.

Again the problem of the medical officers who have been dislocated by the war comes up. It is surprising to know how many men do not intend to go back to their own communities. This is particularly so when we talk to the men who have come from smaller communities. Quite a few are very much interested in having salaried positions and there are a number who are all for affiliating themselves into a group clinic.

From Lt. Colonel James N. Greear, Jr., c/o Postmaster, New York, N. Y.:

Dear Ted: In my travels I have an opportunity to see a great many Washington men and have discussed with them, as

well as many from other communities, the question of the future of medicine. This is a subject in which they are all vitally interested, and they have had a great deal of time to think about it. They feel very definitely that the men who are staying home should be held responsible in a large part for drastic changes in the practice of medicine. However, everyone realizes that changes are inevitable and possibly necessary. Still, the medical profession can exert a definite influence on these changes if they make it their business to.

My work here is extremely interesting and I am having an opportunity to see patients at a much earlier period than I had back in the States.

Please remember me to all my friends. . . .

From Captain T. Frasier Williams, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: Just a short note to tell you that the letters are coming through. I appreciate them very much. The only suggestion that I have to offer on the plans for medical care is to continue the aggressive action already taken. To be a success it must be done with enthusiasm.

We are with the Third Army and really making big news now.

From Lt. Colonel Worth B. Daniels, Harmon General Hospital, Longview, Texas:

Dear Mr. Wiprud: Your letter of 29 January was forwarded to me from the Philippines to this station. I'm glad to have it and the membership card.

I have recently reported for duty as Chief of Medical Service here at this center for the treatment of tropical diseases. The job is excellent and most interesting.

From Comdr. A. J. Mourot, U. S. Navy Hospital, Charleston, S. C.:

Dear Mr. Wiprud: I wish to thank and congratulate you on your excellent news letters. It is encouraging to us in the

Service to know that the Society is trying to formulate plans for our return to civilian practice, even though these plans cannot be too definite as we have little idea when that happy day will be.

For the past 8 months I have been Chief of Surgery at this, a 1,000-bed, general hospital. Approximately 50 per cent of our patients are Southwestern Pacific casualties. They are evacuated to San Francisco, Calif., then brought cross-country by special trains or by plane. From their stories, Iwo Jima was the worst of all the campaigns—even worse than Tarawa.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the business meeting, May 2, 1945:

Active Members

Arthur S. Bauer, 1801 Eye Street, N.W.
Karl H. Langenstrass, St. Elizabeths Hospital
Henry Simmons Murphy, 1328 Eye Street, N.W.
Anna Neumann, 900—17th Street, N.W.

Associate Members

John Philip Clum, 6110—43rd Avenue, Hyattsville, Md.
Leo Ignatius Donovan, 8016 Georgetown Road, Bethesda, Md.
Elizabeth Adams-Koppel, 703 Garland Avenue, Takoma Park, Md.
Joseph S. Lawrence, 1835 Eye Street, N.W.

The following applicants for membership will be voted on at the business session, October 17, 1945:

For Active Membership

Samuel Millard Bageant, Georgetown University—1933
Clifford Edward Bagley, Temple University—1934
John Edward Cassidy, Georgetown University—1942
John Andrew Collins, Washington University, St. Louis, Mo.—1902
Charles Fichman Forester, University of Vienna, Austria—1937
Maurice Franks, Harvard University—1939
Louis J. Goffredi, George Washington University—1938
George Kriegman, University of Illinois—1943
Thomas Miles Leonard, Rush Medical College—1937
John Aloysius Long, Georgetown University—1942

For Associate Membership

John William Cronin, University of Cincinnati—1933
Isabelo R. Villaroman, University of the Philippines—1935
Jonathan Zoole, Temple University—1933

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ANNOUNCEMENT TO PHYSICIANS AND HOSPITAL SUPERINTENDENTS

In line with the policy of supplying physicians and hospital superintendents with therapeutic and biologic agents for the treatment of medically indigent patients in the District of Columbia, the Health Department, through its bureaus of Venereal Diseases and Preventable Diseases, will begin distribution of penicillin on May 20, 1945.

Physicians are requested not to apply for penicillin except for medically indigent patients. Applications also will not be honored unless physicians report and identify the cases under their care and the nature of the infection being treated.

GEORGE C. RUHLAND, M.D.
Health Officer

On The Home Front

The American Medical Association has been denied a permit to hold an annual meeting of the House of Delegates in Chicago, July 23 to 25, by the War Committee on Conventions. Efforts may be made to hold a meeting in the fall.

Dr. A. F. Kreglow was host to the **Section on Gastroenterology** at his home, May 14. Major Charles A. Flood of Walter Reed Hospital, formerly of Presbyterian Hospital, New York City, spoke on "The Problem of Duodenal Ulcer in the Army." Dr. Daniel L. Borden discussed his paper from a surgical viewpoint.

The **Section on Pediatrics** met April 19 in the Society's library. Drs. Frederic G. Burke and Sydney Ross, of Children's Hospital, presented a "Preliminary Report on Oral Administration of Penicillin."

The Federal Works Agency, on September 8, 1944, made a grant to **George Washington University** in the amount of \$2,700,000 for the construction of a new hospital to occupy the block bounded by 22nd and 23rd Streets, Eye Street and Washington Circle on Pennsylvania Avenue, Northwest, the faculty of George Washington University School of Medicine to control the hospital.

CALENDAR OF MEETINGS

May 2	Annual Business Meeting of Society
May 9	Scientific Meeting of Society
May 14	Grievance Committee
May 15	Special Building Committee
May 16	Scientific Meeting of Society
May 21	House Committee

The 400-bed structure, six stories high, will be equipped and managed as a "teaching hospital," replacing an older building in use since 1898. The main entrance will be on 23rd Street, N. W., between Pennsylvania Avenue and Eye Street, with the ambulance entrance at 23rd and Eye Streets. There will also be an entrance to the hospital on 22nd Street, and a large parking area for doctors' cars along 23rd Street.

The building will be well lighted and ventilated. The main portion of the structure will contain the nursing services, administration and the service departments. Its size is controlled by the number of beds required and their distribution. The north wing will contain the outpatient services, the operating and obstetrical suites. These are purposely segregated from the rest of the hospital and are



NEW GEORGE WASHINGTON UNIVERSITY HOSPITAL

concentrated for the purposes of convenience and economy.

Special provisions have been made in the Obstetrical Division for the care of the newborn. Dr. John L. Parks and Dr. Preston A. McLendon of the Departments of Obstetrics and Pediatrics, respectively, have initiated a plan which places the Obstetrics Department on the third floor of the new hospital. Small nurseries, ranging in size from one bed to eight beds at a maximum, will be in close proximity to the mothers' wards so that infants

may be taken to their mothers with the least possible "corridor exposure" and will provide opportunity for "education" of new mothers in child care.

A large outpatient department to provide treatment for the indigent and semi-indigent will occupy two floors and one end of the new hospital. This department will feature a very modern eye clinic, including an aniseikonic clinic, orthoptic clinic and glaucoma clinic, as well as one for refraction and treatment of general diseases of the eye.

The Physical Medicine Department, another important feature of the new hospital, will be well equipped with modern devices, including water tanks for hydrotherapy and devices for scientific uses of electricity.

The New George Washington University Hospital will be ready for occupancy in about eighteen months. Mr. Leo G. Schmelzer, who was recently appointed Superintendent of the Hospital, will supervise its construction and equipment. He will assist Dr. Walter A. Bloedorn, Dean of the School of Medicine and Medical Director of the Hospital.

A campaign for funds to build a new **Georgetown University Hospital** has been launched, with an objective of \$750,000. The campaign goal is the



NEW GEORGETOWN UNIVERSITY HOSPITAL

amount needed to supplement and guarantee a Federal grant of \$1,820,000, provided under the Lanham Act for construction of the new building. Estimated cost of the completed project is \$2,570,000 and the Government's appropriation is contingent upon the University's providing the balance needed beyond the grant.

Mr. James E. Colliflower, of Washington, an alumnus of the University, has been named chairman of the fund appeal, and a soliciting organization is now being formed in Washington and other cities where friends of the University reside.

The projected hospital, which will have a capacity of 400 beds, will be erected adjacent to the University Medical and Dental Schools in the 3900 block of Reservoir Road, N. W. It will rise to seven stories in the center section. Features of the new structure will include three sun decks, four solariums, an obstetrics department of 100 beds with adjacent nurseries, a pediatrics department of 30 beds, twelve operating rooms, and a large, modern outpatient department.

The new building will replace the old Georgetown University Hospital, at 35th and N Streets, N.W., with a capacity of 235 beds, erected in 1898. The Very Rev. Lawrence E. Gorman, President of Georgetown University, points out that the new

building will not only provide 165 more beds than the old hospital but also will bring a number of other medical benefits to the community. He said:

"Much of the equipment and many of the accommodations in the present hospital are inadequate and outmoded. The new building will provide the latest scientific apparatus and structural facilities for the fullest employment of the most modern developments in medicine and surgery.

"The new institution will also broaden the scope of the Georgetown University School of Medicine by educating more doctors and more nurses to fill a need that is urgent both here and throughout the Nation."

Father Gorman said plans include provisions for the establishment of memorial units. Under this arrangement, a donor may designate a section of the hospital—such as a ward, nursery or building wing—as a memorial to perpetuate the name of a friend, relative or family. Each unit will be marked with a plaque. Father Gorman commented:

"A memorial gift will combine sentiment with service to the sick and afflicted. The new hospital will endure for many generations and a memorial within its walls will provide a lasting tribute to the one in whose memory it is given."

One of the most successful events of the year was the 48th Annual Dinner Meeting of the **Washington Medical and Surgical Society**. In attendance were a large number of guests who enjoyed themselves thoroughly.

Commodore A. W. Clarke, D.S.O., of the British Royal Navy, was the speaker of the evening. He related his experiences as commander of a cruiser escorting convoys to Murmansk, Russia. Speaking in an informal manner, his thrilling story of sea warfare held the closest interest of the audience for more than an hour.

Dr. E. Leonard Goodman, President of the Society, presided. The General Chairman of the Committee on Arrangements was Dr. George J. Ellis. Other officers of the Society present were Dr. George H. McLain, Vice President; Dr. Norman C. Shoemaker, Secretary; and Dr. Frank E. Gibson, Permanent Treasurer. The latter has held his office for many more years than most physicians can recall. He is

indefatigable in his efforts, which are always successful, in making every affair a most pleasant one.

Among the guests of honor were Captain S. W. Roskill of the British Royal Navy, Harold Rogers of the *Evening Star* (Washington) and Theodore Wiprud, Secretary of the Medical Society of the District of Columbia.

The Washington, D. C. Ophthalmological Society met May 28 in the Medical Society's building. Dr. Ernest Sheppard spoke on "Infranuclear Paralysis of the Elevators; Report of Two Cases." Mr. Samuel Berman of New York City demonstrated the Berman Locator. Case presentations were made by Drs. C. R. Naples, M. Noel Stow, Ronald A. Cox and Edward G. Cummings.

The George Washington University Medical Society met May 19 in the Medical Society's library for its annual meeting. Following election of officers several musical numbers were rendered and Dr. Robert H. Harmon delivered his President's Address. Officers who will serve during the coming year are as follows:

Dr. Fred A. J. Geier, *President*; Dr. J. Burton Glenn, *President-elect*; Dr. Howard P. Parker, *First Vice President*; Dr. Naomi Kanof, *Second Vice President*; and Dr. Oscar B. Hunter, *Secretary-Treasurer*.

Dr. Robert H. Harmon was elected to the Executive Council for five years.

The regular meeting of the **Clinico-Pathological Society** was held on May 3 at Hallowing Point on the Potomac River. Dr. John W. Burke was host and entertained with a shad bake. Dr. Chester S. Keefer, Medical Administrative Officer, Committee on Medical Research, Office of Scientific Research and Development, discussed "Penicillin."

At the conclusion of its regular sessions, the **District of Columbia Pharmaceutical Association** held its annual dinner at the Statler Hotel on May 24. There was an unusually large attendance. Among the guests present were Dr. William P. Herbst, recently elected President-elect of the Medical Society of the District of Columbia, and Theodore Wiprud, Secretary of the Medical Society.

Officers and members of the Medical Society of the District of Columbia were guests of the Command-

ing Officer and officers of the **U. S. Navy Hospital Ship U. S. S. Tranquility** on May 13.

The *Tranquility* was anchored in Annapolis Roads. Visitors were ferried from a pier at the Naval Academy to this latest, most modern hospital ship.

Among those who were reported to have been present on the *Tranquility* sometime during the day were Dr. William M. Ballinger, Acting President of the Society, Drs. A. Magruder MacDonald, John L. Parks, John M. Orem and Walter A. Bloedorn.

Following a meeting of the Executive Board, April 30, the reappointment of **Theodore Wiprud** as the Society's representative to serve with the Commissioners' Traffic Advisors for a term ending May 21, 1946, was made to the District Commissioners. **Dr. George K. Nutting** was named Alternate.

The annual banquet of the **District of Columbia Medical Bowling League** was held at the Kenwood Country Club on Thursday, May 17. A large group of bowlers, including many prominent doctors, dentists and pharmacists of the District attended. Major George A. Resta, President of the League, presided. Among those who spoke during the evening were Mr. A. L. Ebersole, Executive Secretary of the National Duckpin Congress, Mr. Jim Berryman, cartoonist, and Mr. R. D. Thomas, sports writer, both from the staff of the *Evening Star*.

Prizes were awarded by Mr. Ebersole. First place in the League was won by Mt. Alto Hospital Team No. 2, captained by Mr. Paul Duffy; second place by the team at the Pentagon, Major A. J. Nicolette, Captain. Third place went to Suburbanite team, captained by Dr. Millard F. Ottman, which, after a recount of pins, displaced Mt. Alto Team No. 1, captained by Major Resta.

Among the guests attending were Dr. William M. Ballinger, Acting President of the Medical Society of the District of Columbia, and Theodore Wiprud, Secretary.

Following the banquet and awards, the bowlers adjourned to the Bethesda bowling alleys where free-for-all sweepstakes were held.

The Medical Bowling League, comprising over eight teams, enjoyed its most successful season since its organization. Over 60 bowlers participated in the League in the course of the season. It is

expected that the League will be even more successful next year. Any doctors who wish to join with the League, or wish to form a team and enter it in the League, should do so before September 1.

The District of Columbia Mental Hygiene Bureau was formally dedicated on Thursday evening, May 3, at the United States Chamber of Commerce auditorium. Mrs. George C. Thorpe, Chairman of the Women's Safety Committee of the American Automobile Association, presided. Speakers on the program were as follows: The Honorable Jennings Randolph, Chairman, District of Columbia Committee of the House of Representatives; Dr. George C. Ruhland, District Health Officer; Dr. Winfred Overholser, Chairman, Committee on Mental Hygiene of the District Medical Society; Dr. John F. Owen, Director of the new Mental Hygiene Bureau; Mr. Charles V. Morris, Secretary, Correction Division, Council of Social Agencies; Mr. Howard B. Gill, General Superintendent of District of Columbia Penal Institutions; Inspector Milton D. Smith, Metropolitan Police Department; Mr. William J. Escavaille, Alcoholics Anonymous; Mrs. Marty Mann, Executive Director, National Committee for Education on Alcoholism; and Rev. Frederick E. Reissig, Executive Secretary, Washington Federation of Churches.

The meeting was sponsored by the Washington Institute for Mental Hygiene, the Women's Safety Committee of the American Automobile Association, the Council of Social Agencies of the District of Columbia and Vicinity, the Washington Federation of Churches and Alcoholics Anonymous.

The Medical Bureau has added 26 new subscribers since the last telephone directory went to press. They are: Drs. Daniel L. Borden, W. Sinclair Bowen, Caroline Burbeau, William Earl Clark, Abe M. Cohen, John V. Dolan, Edward C. Durkin, John E. Everett, Bernard J. Gurwin, J. Blaine Harrell, Eugene Higgins, Harry Hurtt, Elizabeth A. Koppel, Vasilios S. Lambros, William B. Marbury, William C. Meloy, J. Ernest Mitchell, Anna Neumann, R. Massie Page, Alex A. Preece, Barton W. Richwine, Benjamin Stein, John E. Virstein, James C. Waters, Jacob Weinstein and Albert S. Winer.

Abbott Laboratories, of North Chicago, Illinois, has presented the War Department with a large collection of paintings as a permanent pictorial record of achievement of the Army Medical Corps. The collection was on display at the Corcoran Art Gallery from May 14 to June 3.

Twelve artists were commissioned for the task, with the consent and coöperation of the War Department. They were Robert Benney, Franklin Boggs, Howard Baer, Joseph Hirsch, Lawrence Beall Smith, Peter Blume, Francis Criss, John Steuart Curry, Ernest Fiene, Marion Greenwald, Fred Shane and Manuel Telegian.

Two reasons were given for the undertaking: first, to manifest the progress made in medicine and surgery in recent years, and second, through such knowledge to give comfort and reassurance to those whose loved ones were, and are, subjected to war's hazards.

The pictures were formally presented by S. DeWitt Clough, President of Abbott Laboratories, to Major General Norman T. Kirk, Surgeon General of the Army, at the Carlton Hotel, May 13, preceding the opening of the exhibit. President and Mrs. Harry S. Truman were among those who attended the opening of the exhibit.

Dr. Harry F. Dowling, Clinical Professor of Medicine, George Washington University School of Medicine, spoke over WINX, May 25, on the subject, "Chemotherapy." His talk was one of a radio series, "The Doctors Talk It Over," presented by Lederle Laboratories, Inc., over the Blue Network each Friday evening at 10:30 p.m. Other speakers during the month of May were Dr. Roger I. Lee, President-elect of the American Medical Association; Dr. Alan Gregg, Director for the Medical Sciences of the Rockefeller Foundation; and Dr. T. Duckett Jones, Research Director in Rheumatic Fever and Rheumatic Heart Disease, House of the Good Samaritan, Boston.

Dr. Winfred Overholser was the principal speaker at a dinner meeting reunion of the Boston University Medical Alumni, May 12.

Dr. Robert Oden, for 23 years a practicing physician in Washington, has been decorated with the Order of the Commander of St. Olaf by King Haakon

of Norway. Dr. Oden, who was born in Sweden, has been a resident of Washington and a citizen of the United States for many years. After graduating from George Washington University School of Medicine in 1919, he continued his medical education, studying at Johns Hopkins Hospital and at clinics in Paris, London, Berlin and Vienna before the war. On his return to the United States he was a member of the staff of Johns Hopkins Hospital for two years. He was decorated with the Order of the North Star by the King of Sweden in 1920. He also holds membership in the International Rheumatic Society of Holland.

Leslie Fonkalsrud assumed his new duties as Superintendent of **Episcopal Eye, Ear and Throat Hospital**, May 1. He succeeds Deaconess Anna E. Macdonald, who resigned recently.

Mr. Fonkalsrud, a graduate of the University of South Dakota, was formerly Administrator of the Lima (Ohio) Memorial Hospital. For several years he was associated with his father, Dr. A. O. Fonkalsrud, Administrator of Mansfield (Ohio) General Hospital, as Business Manager and Financial Secretary of the Hospital. Commissioned a Lieutenant in the Medical Administrative Corps of the Army in 1942, he served as fiscal officer and personnel officer at the station hospitals at Fort Bliss, Texas, and Camp Bowie, Brownwood, Texas. He was retired to inactive status in December, 1943, and subsequently received his formal discharge.

Dr. Joseph S. Wall read a paper before the Columbia Medical Society in Columbia, S. C., May 14. The subject of the paper was "Pneumonias in Children."

The Board of Directors of the District of Columbia Tuberculosis Association elected the following officers, May 8, to serve during the coming year: Miss Jane M. Hoey, *President*; Dr. Walter K. Meyers, *Vice President*; Dr. Howard M. Payne, *Secretary*; and Mr. Alfred H. Lawson, *Treasurer*.

Miss Hoey is Director of the Bureau of Public Assistance of the Social Security Board. She succeeds Mr. Paul D. Sleeper in office. Mr. Lawson is Vice President of the Washington Loan and Trust Company, and Dr. Payne is a member of the staff of Freedmen's Hospital.

Two members of the Medical Society of the District of Columbia are serving on the Board of Directors of the Association, Dr. Clayton B. Ethridge and Dr. Irving W. Winik.

The American Cancer Society launched its campaign in Washington for funds at a luncheon given at the Statler Hotel on May 22. Dr. Eliot Wadsworth, who heads the District committee, presided. Speakers were Senator Leverett Saltonstall of Massachusetts and Dr. Frank E. Adair, President of the American Cancer Society. Among the District physicians at the speakers' table were Dr. William Earl Clark, President-elect of the Medical Society of the District of Columbia; Dr. J. W. Lindsay, Director of the Warwick Memorial Clinic; and Dr. Winfred Overholser.

BOOK REVIEWS

The March of Medicine, No. IX of The New York Academy of Medicine Lectures to the Laity, 1944. THE COMMITTEE ON LECTURES TO THE LAITY. Price, \$1.75. Pp. 121. New York: Columbia Univ. Press, 1945.

The splendid efforts of the New York Academy of Medicine to acquaint the laity with progress in medicine should not only be commended but widely imitated. For the sixth consecutive year they have felt the education of the general public to be of sufficient importance to provide a very readable volume based on the previous year's lectures to the laity.

This book makes profitable reading for the physician to double-check his own knowledge of "War and the Expanding Frontiers of Medicine," i.e., morale, food, chemotherapy, changing practice, effects of the development of science, wars and epidemics. It can also be highly recommended by the physician to his lay friends interested in world problems.

Particularly well presented is Dr. Edward A. Strecker's article on "Morale and Propaganda." Humanity as a whole has grasped the importance of group morale for centuries, but do we as individuals cultivate it to the highest possible degree? "Morale is at once the most intangible and the most real thing in the world. It bears the same relation to the mind and personality of a man as does conditioning to the body of an athlete . . . Morale is faith in our work. It is devotion to a cause. It is the conviction of our destiny" (page 4). Thus Dr. Strecker points out the heights to which individual morale should rise, and subsequently points out the

value of honest propaganda to the development and strength of a democracy.

Charles Olen King, Ph.D., refreshes our minds on dietary requirements and gives us a resumé of the slow development of government requirements in the field of nutrition, with special emphasis on the recent fine accomplishments of the Food and Nutrition Board of the National Research Council.

The sulfonamide drugs and penicillin are being discussed constantly by the laity. Dr. Colin M. MacLeod gives a very clear account of their development and use which should help clear up some of the mistaken conceptions evolving around the powers of these drugs. The chapter offers excellent background material in the history of the comparatively recent development of chemical drugs.

Dr. Reginald Fitz discusses the growth of medicine. To improve education and research is vital. He discusses the beginnings of public health, and emphasizes that if national health is to improve as much as possible physicians and the public must work together and be receptive to each other's ideas.

In "The Effects of Science Upon Human Beings" Sir Gerald Campbell cites some of the deplorable effects so far and voices the hope that scientists will not only go on freeing and enriching human life, but will be the very ones to point up "the urgency of attending to those other problems of human relationships which must be solved if civilization is to advance into that spacious era which science is laying open to us" (page 92).

According to Lt. Colonel Thomas T. Mackie, M.C. A.U.S., more wars have been won or lost due to epidemics than to any other one reason. Thus by historical analysis he emphasizes how influential the growth of medicine is on the political and economic history of the world, and vice versa.

Thus medicine marches on, its sure progress constituting one of the brighter spots on the horizon.

M. B. Y.

Minor Surgery. HUMPHREY ROLLESTON AND ALAN MONCRIEFF, Editors. Price, \$5.00. Pp. 174, with 30 illustrations. New York: Philosophical Library, Inc., 1944.

Eighteen British authors, all recognized specialists in their respective fields and all holding positions of responsibility in English hospitals, have contributed to this work entitled "Minor Surgery."

Unlike many of our American textbooks, the approach to the various problems of minor surgery has followed anatomic classification. To this end, the contents of the book must be searched to guide the reader to any given subject.

Minor surgery is difficult to define and many surgeons regard all operative procedures in the light of a major procedure. As stated in this work on minor surgery, to those who differentiate between major and minor surgery, it is well to remember that any surgical procedure is a major event to the patient. Certainly, many of the surgical procedures described in this text could properly be classified by the profession as major operations, such as amputation of the cervix, cystotomies, tonsillectomies, hemorrhoidectomies, the application of X-ray and radium.

The first two chapters of the book are devoted to Wounds and Sprains. Anatomic designations are given many of the following chapters, which include the Feet, Hand, Mouth, Nose and Throat, Ear, Eye, Rectum, Genitourinary System and Gynecological problems. The diseases of childhood, particularly the surgical approach to pediatrics, and a final chapter on Analgesia and Anesthesia complete the book.

The use of cocaine locally and by spray advocated in the chapter on Nose and Throat might be criticized in this country where less toxic drugs are in common use.

Thirty illustrations and a vast amount of material are packed into the 155 pages that comprise this recent work by recognized British surgeons.

D. L. B.

Alcoholics Are Sick People. ROBERT V. SELIGER, M.D., Assistant Visiting Psychiatrist, Johns Hopkins Hospital, in collaboration with VICTORIA CRANFORD; edited by HAROLD S. GOODWIN, B.A. Price, \$2.00. Pp. 80. Baltimore: Williams & Wilkins, 1945.

This little volume, written by a psychiatrist who has had long experience in treating abnormal drinkers, presents in condensed and simple form a few fundamental concepts of what alcoholism is and what to do about it. He starts with the thesis, so obvious that it is too often overlooked, that the alcoholic is a sick person and should be dealt with as such, provided that he understands three things: (1) that he is fundamentally different from other drinkers; (2) that he should seek aid immediately; and (3) that he can now find aid through medical science (page 4).

He discusses the principal types of mental mechanisms which may manifest themselves in abnormal drinking, and then proceeds to point out what psychiatry is and is not, and how it can be helpful to the alcoholic who seriously desires cure. In Chapter 9 the author gives 35 sound and succinct paragraphs containing "guides for the abnormal drinker."

Prejudices against the alcoholic die hard, and it is by just such ventures as this book, repeated and repeated again, that some progress in public education may be

expected. The book is written in such terms that he who runs may read; it deserves a wide circulation.

W. O.

Modern Methods of Amputation with an Introductory Survey of the Development of Amputation by Major General Norman T. Kirk, M.C., Surgeon General, U. S. Army. EDMUNDO VASCONCELOS, Professor, University of Sao Paulo. Price, \$10.00. Pp. 253. New York: Philosophical Library, Inc., 1945.

This late, profusely illustrated work on amputations consists of the official report submitted at the Third Brazilian and American Surgical Congress held in Rio de Janeiro in November 1941. Written in collaboration with Edgard Pinto DeSouza and Jose Goncalves Filho it covers the entire field of the surgical and clinical approach to all types of amputations. All the drawings are original, made from the cadaver under the direct supervision of the author. These are of special value to the student for they clarify the functional values of the various parts of the extremities and mark the site of election for amputation.

An introduction of this work is written by Major General Norman T. Kirk, Surgeon General of the U. S. Army, who in his own right is the author of a textbook on amputations. General Kirk has covered the Development of Surgery in Amputations from the practices of primitive people to the modern approach and practice of present-day technic.

Professor Vasconcelos in six chapters covers the general principles, indications, technic, including the use of local anesthesia in all the various types of amputations. The final chapter of this work is a practical dissertation on Prosthesis for Amputations. Two hundred and fifty-eight illustrations clarify the text and complete a thorough and exhaustive study of all phases of amputations.

D. L. B.

Mental Health—Overholser

(Continued from page 247)

worth while to bear in mind that the prognosis for service breakdowns of a mental nature is, all in all, substantially better than for similar symptom-pictures in civilian life. The most of the men who receive discharges from the services for a type of disability labelled, with unnecessary cumbersomeness, neuropsychiatric (for probably about 90 per cent of the cases are psychiatric rather than neurologic) can confidently be expected to make a working adjustment to civilian life approximately as good as the one they were making before their enlistment, provided, of

course, that they are met with suitable employment situations and an attitude of helpfulness and understanding on the part of their families and friends.

Mental health, like health in general, is something more than mere absence of disease. It involves readiness to face reality without evasion, to deal with one's problems forthrightly in accord with generally accepted standards of behavior, to view one's self with due perspective, to meet the impact of the personalities of those about us with tolerance, sympathy and generosity. To do these things one must have emotional maturity (and much of this depends upon wise up-bringing) and at least moderate security, an assurance of the esteem of one's fellows. All these assets assume the existence of a well-functioning physical organism. When threats to one's security, one's self esteem or one's physical intactness, be it from advancing years or from disease, come about, an extra strain is put upon the mechanisms of adjustment, and symptoms may develop which may be termed "nervous" or (usually its equivalent) "mental." It is at times like this, whether dealing with aged or youth, man or woman, soldier or civilian, that the physician has his golden opportunity to be guide, mentor and friend as well, and in the widest and best sense, to practise practical preventive psychiatry.

Direct Inguinal Hernia—Cox and Forrest

(Continued from page 255)

3. ORR, T. G.: Operations of General Surgery. Philadelphia: Saunders, 1944.
4. CHRISTOPHER, F., Editor: Textbook of Surgery, 3rd ed. Philadelphia: Saunders, 1942.
5. SHELLEY, H. J.: Direct inguinal hernias. Arch. Surg., 1940, 41, 857.
6. GILL, W. G.: Direct inguinal hernia. Brit. M. J., 1939, 1, 263.

In and Out of Focus—Observer

(Continued from page 268)

around to it. Undoubtedly it was due in part to their indifference to financial matters.

Not so very long ago a physician who had been engaged in practice in Washington for many years died. Apparently he had been successful and it was thought that his elderly wife would never be in want. It was shocking to learn after his death there was nothing left to his widow. That despite her advanced years it would be necessary for her to seek work. This is not the only instance of this kind within the memory of your Observer since he came to Washington.

The Philadelphia County Medical Society, cognizant of the frequency of such cases, long ago did something about it. In its publication, *Philadelphia Medicine*, the editor sums up the situation of families of unthinking physicians.

"Living comfortable lives and enjoying many of life's luxuries as is usual with physicians' families," he writes, "the unexpected death of the head of the house suddenly and without warning leaves them destitute. If the doctor has passed away in the prime of his life there may be young children to add a mountain of worry on the shoulders of his young widow, who has so suddenly been translated from comfort to destitution."

"Probably most of us feel that *we* won't leave *our* families in want when the Grim Reaper calls us. We may even have the complacent feeling that those doctors who have not left their families well provided for have been improvident and culpable. It should be kept in mind that those doctors, too, while they lived feel as we do now. No one knows what Fate holds in store for us."

Fortunately for many members of the medical profession in Philadelphia the Society many years ago organized The Aid Association to render assistance where physicians' families are in financial difficulties. "Unobtrusively and without fanfare its Benevolence Committee sees that the deserving widows and families of deceased physicians as well as aged and disabled physicians themselves receive checks to provide the necessities."

Some years ago your Observer made a study of the Association for the purpose of reporting to a committee of the Society which at that time was considering establishing a similar organiza-

tion here. However, nothing came of it. Perhaps it would be well to revive the matter in the interest of Washington physicians' families who may need such protection as is afforded in Philadelphia.

Adoption Regulations—Morss

(Continued from page 271)

health, temperament and mental make-up.

5. A record of the child's background is kept safeguarded for his future need. The child has the right of knowing his own antecedents and this information should be made available to him when he becomes an adult with the consent of the adoptors.

There are six social service agencies in the District of Columbia whose traditions and programs have given them long experience in adoption work. They are the Children's Protective Association, 1907 S Street, N.W., the Catholic Charities, 1441 Rhode Island Avenue, N.W., the Jewish Foster Home, 1135 Spring Road, N.W., the Methodist Board of Child Care, 2nd and Rittenhouse Streets, N.W., St. Ann's Infant Asylum, 2300 K Street, N.W. and the Board of Public Welfare, 470 Indiana Avenue, N.W. The Board of Public Welfare as the public child protective agency has particular responsibilities under provisions of Public Law 397 to provide services to unmarried mothers and children born out of wedlock. Since the enactment of Public Law 292, it has developed a department in charge of Mrs. Nina Trevett to provide information and help to the mother referred because of the problem of illegitimate pregnancy and to receive and study the applications of persons desiring to adopt children in order to find suitable homes for children whom mothers wish to relinquish. Since October of 1944, 160 unmarried mothers have been referred by lawyers, doctors and social agencies, or the mothers themselves have come to the agency for help. Of the children who have been born 40 have been relinquished by the mothers for adoption placement and are now in trial adoption homes. The agency is located at 470 Indiana Avenue, N.W., telephone Republic 1655.

Annual Report of Woman's Auxiliary

(Continued from page 275)

The Auxiliary purchased a \$500 War Bond.

From the benefit luncheon held in the fall more than \$350 was realized.

The Spring Tea, honoring the wives of men prominent in the Services, was a delightful affair.

Our Red Cross Unit, under the guidance of Mrs. Charles McEnerney, has met every week and has made many hundreds of dressings. Most of the members have been active as Motor Corpsmen, Nurses' Aides and Grey Ladies, or have helped in the various U.S.O. Clubs.

Our speakers have been men and women of local, national and international interests.

At the final meeting in May the following officers were elected: Mrs. William Earl Clark, *President*; Mrs. Arch L. Riddick, *First Vice President*; Mrs. George H. Crofton, *Second Vice President*; Mrs. Richard H. Todd, *Recording Secretary*; Mrs. Duane C. Richtmeyer, *Corresponding Secretary*; Mrs. Harry S. Lewis, *Treasurer*.

We wish the new officers success in the coming year.

I feel it a great honor to have been President of the Auxiliary and wish to thank the members of my Executive Board, Committee Chairmen, and all the members of the Auxiliary for their help and support during the year.

MRS. JAMES N. GREEAR, JR.

President

Membership

(Continued from page 277)

Recent changes in membership status:

Active to Associate

William C. Sparks*
Dorothy V. Whipple

Resigned Active Members

Philip S. Arthur
William DeKleine

Resigned Associate Member

Charles F. Church

* Dr. Sparks resigned as an Active Member but at his request was later reinstated by the Executive Board as an Associate Member.

MEDICAL ANNALS

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1944 POLIOMYELITIS EPIDEMIC

Analysis of Cases Seen at Children's Hospital, Washington, D. C.

THE COMMITTEE ON POLIOMYELITIS

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Washington

THE largest number of cases of poliomyelitis occurring in the District of Columbia and the metropolitan area were seen in 1944. Two hundred and five or approximately 66 per cent were admitted to the wards of Children's Hospital. Of these, 100 were residents of the District of Columbia, 68 were residents of Maryland, and 37 originated in nearby Virginia. One hundred and seventy-five of the group occurred in the white population, while 30 were colored; males outnumbered females by 117 to 88. This latter figure is near that of the usual outbreak.

The usual seasonal curve was evident, the peak being reached in August. The peak of the next largest outbreak, 1941, was reached in September. In each year the first cases appeared in late June and early July. Sporadic cases appeared as late as December.

The age incidence was as follows:

Under 1 year.....	11 cases
Two to 3 years.....	36 cases
Three to 7 years.....	49 cases
Seven to 13 years.....	109 cases

Older children were not accepted at this hospital. This preponderance of susceptibility at the (approximate) 10-year age level is not explainable with our present knowledge of the epidemiology of the disease.

The average elapsed time from the onset of symptoms to admission to the hospital was 6 days.

Since the prodromal symptoms of poliomyelitis are commonly confusing, this 6-day interval reflects credit to the alertness of the attending physicians. Nine patients were admitted with the diagnosis of poliomyelitis which were subsequently proven otherwise.

Hospital care for victims of poliomyelitis has always been notoriously prolonged. Although more than 50 per cent of the 205 patients were discharged within 30 days, the average stay has been increased to 76 days. This increase is due to those remaining in for 60 to 90 days and the small group of 15 now spending their ninth and tenth months in the hospital.

Tonsillectomy as an antecedent to poliomyelitis played a minor role. Two patients had been operated on 1 month prior to the onset; 1 of these had the bulbar type. Three other patients had been operated on within the previous year. No tonsillectomies were performed in the hospital from July 15 to November 1. The Committee felt that this precaution should be taken. A number of occurrences of the bulbar type of poliomyelitis are reported following tonsillectomy during the seasonal incidence of the disease.

SYMPTOMATOLOGY

The symptom-complex at the onset of poliomyelitis does not present a too significant picture of the disease when evaluated against that of other acute infections encountered in children. The following table gives the frequency of symptoms elicited in the special type of the illness, whether paralytic or non-paralytic:

Symptom	Percentage	Symptom	Percentage
Fever	74	Abdominal pain	18
Headache	55	Back pain	15
Muscle pain	54	Mental symptoms	7
Muscle weakness and paralysis	50	Anorexia	6
Stiff neck	49	Difficult urination	2
Vomiting	29	Diarrhea	2
Coryza	27	Convulsions	0.5
Stiff back	23	Joint symptoms	0.5

Fever probably occurred in 100 per cent of these patients, although a history of rise in temperature was elicited in only 74 per cent. The less severe, non-paralytic cases very possibly have a fraction of a degree which escapes observation. Headache might be more significant if members of the younger age group could

express their symptoms. Muscle pain should and does compel attention, although here again this is encountered in many acute infections. This pain is most frequently in the leg muscles and next in the back muscles. Stiff neck is significant of meningeal irritations in general, and spinal fluid findings are the criteria of causation.

The onset of the bulbar type poliomyelitis is usually more significant, since more concrete deviations from normal occur. Difficulty in swallowing and changes in the voice can easily be detected by the parent, while facial weakness or paresis of the palate, as observed by the physician, add up to a composite not to be ignored. The bulbar group of patients encountered in this series evidenced the following group of findings in their relative frequency:

Symptom	Percentage	Symptom	Percentage
Swallowing difficulty	76	Pulse irregularity	29
Voice change	66	Encephalitic symptoms	26
Palate paresis	50	Tongue paresis	19
Facial nerve paresis	40	Diplopia	5
Respiratory difficulty	40		

Facial muscle weakness was usually of a transitory nature. Lethargy was the prominent encephalitic symptom noted. Voice change was common and its frequency of occurrence depends no doubt on the familiarity of the examiner with this function and the coöperation of the patient. As stated above, only 2 patients had recently (within 1 month) had a tonsillectomy.

While spinal fluid findings were consistent with those reported in other epidemics, the cell count was somewhat higher in the bulbar group.

Muscle spasm was present in some part of the body in all cases diagnosed as poliomyelitis. A stiff neck or back was usually present, this stiffness continuing over a much longer period, in relation to fever, in comparison with types of purulent meningitis. Spasm of the hamstring muscles was also invariably present as evidenced by the positive Kernig's sign. No explanation can be given for this persistence of muscle spasm beyond the acute inflammatory stage. This spasm is seen frequently in the gastrocnemius

and pectoral muscles. Interestingly, the muscles opposed to the spastic group have deficient function. This lack of function may signify paresis or alienation (if one wishes to accept the Kenny interpretation). The function of these muscles returns when spasm is relieved.

An analysis of the 205 patients showed 38 to have had bulbar involvement. Twenty-six of these had concomitant spinal nerve pathology. Fifty-four of the remaining 167 patients had no paralysis. One hundred and thirteen patients had definite paralysis of 1 or more muscles. A few patients were carried as non-paralytic for several weeks before definite decisions could be made. Only after moderate exercise was allowed did these patients evidence definite muscle weakness. Prolonged observation for signs of weakness cannot be too strongly urged.

Death occurred only in the bulbar group, 6 in number, the mortality rate for the whole group being 2.9 per cent.

NON-PARALYTIC CASES

Fifty-four cases were separated from the total and evaluated as having no paralysis. These patients were kept under observation for a sufficient time to eliminate any possibility of a residual paralysis escaping notice. Muscle spasm was negligible before they were released. The methods of treatment included the "Kenny technic," the use of prostigmine, the use of prostigmine and the "Kenny technic," and simple bed rest. The "Kenny technic" consisted in the application of hot packs and prone packs changed at hourly intervals during the day. The "Kenny technic" was supplemented by physiotherapy given by Kenny-trained technicians. Prostigmine was given as prostigmine hydrobromide solution 1:2000 in 1 to 2 c.c. doses twice daily. Thirty-three patients received Kenny treatment, and complete recovery was obtained in an average of 10 weeks. Of the 10 patients receiving Kenny treatment and prostigmine, recovery was evident at an average of $8\frac{1}{2}$ weeks. Three patients were

given prostigmine alone, but only 1 could be followed to recovery at 3 weeks. The average time of treatment in the 54 non-paralytic cases was 9 weeks. This was found necessary after several patients had been discharged early, only to return with considerable muscle weakness.

SPINAL PARALYTIC CASES

The paralytic cases represent the group most of us are interested in and they also represent the group on which results of treatment are evaluated. Cases of poliomyelitis vary so much in severity and involvement that it is a difficult problem to evaluate any treatment. A residual paralysis may be 1 muscle, such as the anterior tibial, or it may be the entire musculature of the 4 extremities. Each case must be considered as a poor anatomic result if 1 or more muscles are paralyzed, yet functionally the patient may be nearly perfect. Many of our patients with residual paralyses have excellent functions. Because of these variations we felt it was important to evaluate these paralytic cases according to the anatomic recovery and also as to the functional recovery.

One hundred and fourteen patients with the spinal paralytic type were admitted. Sixty-two patients received Kenny treatment only. Forty-one patients received prostigmine in addition to Kenny treatment and 4 patients received ultraviolet blood irradiation in addition to Kenny treatment. Five patients received prostigmine alone, and 1 patient received no special treatment. The latter patient was sent home by the private physician after 12 days, and no follow-up is available.

In the comparison of the different groups we felt that the severity of the individual cases could best be represented by dividing the body into units, each arm and leg representing 1 unit each, the back 1 unit, the neck 1 unit, the abdomen 1 unit, and the thorax 1 unit. Thus a patient with 1 unit involvement would mean that only 1 limb, or the neck, or the back, or the abdomen would be affected, while if it were a

TABLE 1
Results in Paralytic Cases

INVOLVEMENT IN UNITS	NO. OF CASES	NO. OF CASES FOLLOWED	C.N.R.	ANATOMIC RESULTS				FUNCTIONAL RESULTS			
				B	G	F	P	E	G	F	P
Kenny treated											
1	24	22	9	2	3	4	4	4	8	1	0
2	24	21	8	4	1	1	7	5	4	2	2
3	5	4	0	0	1	1	2	1	1	1	1
4	5	4	1	1	0	0	2	1	0	1	1
5	2	2	0	0	0	0	2	0	0	0	2
6	2	2	0	0	0	0	2	0	1	0	1
Total.....	62	55	18	7	5	6	19	11	14	5	7
Kenny and prostigmine treated											
1	10	9	2	1	1	2	3	2	1	3	1
2	18	15	5	4	4	1	2	5	4	1	1
3	3	2	0	1	0	1	0	2	0	0	0
4	5	4	0	0	2	1	1	0	3	1	0
5	2	1	0	0	1	0	0	0	1	0	0
6	1	1	0	0	1	0	0	0	1	0	0
7	2	1	0	0	0	0	1	0	0	0	1
Total.....	41	34	7	6	9	5	7	9	10	5	3
Prostigmine treated											
1	3	1	1								
2	1	0	0								
4	1	1	1								
Total.....	5	2	2								
Ultraviolet blood irradiation and Kenny treated											
1	1	1	1								
2	3	2	2								
Total	4	3	3								
No treatment											
2	1	0	0								
Total.....	1	0	0								
Grand total	113	94	30				26				10

Explanation:
Unit—A unit equals 1 limb or portion of the body
C.N.R.—Complete Normal Recovery
B—Border Case
G—Good Result
F—Fair Result
P—Poor Result
E—Excellent Result

7-unit involvement it would mean that practically the entire body was involved. It must be borne in mind that this unit evaluation may signify the involvement of 1 muscle or a group of muscles.

Twenty-four of the 62 cases in this first group were 1-unit cases, 24 were 2-unit cases, 5 were 3-unit cases, 5 were 4-unit cases, 2 were 5-unit cases, and 2 were 6-unit cases. These data are shown in table 1. The involvement included 43 right legs, 37 left legs, 13 right arms, 15 left arms, 7 abdomens, 10 necks, 6 backs, and 1 thorax (see table 2).

TABLE 2
Spinal Paralytic Involvement

PART INVOLVED	TREATMENT GIVEN					
	K	K,P	P	K,UBI	N	Total
Right Leg.....	43	31	2	4	1	81
Left Leg.....	37	30	4	3	1	75
Neck.....	10	10	0	0	0	20
Right Arm.....	13	7	2	0	0	22
Left Arm.....	15	6	1	0	0	23
Back.....	6	8	0	0	0	14
Abdomen.....	7	4	0	0	0	11
Thorax.....	1	1	0	0	0	2

Explanation:
K—Kenny Treated
KP—Kenny and Prostigmine Treated
P—Prostigmine Treated
K,UBI—Kenny Treated and Ultraviolet Blood Irradiation
N—No Treatment

The number of days of treatment were 25 or less in 15 cases; 25 to 50 in 17 cases; 51 to 100 in 14 cases; 101 to 200 in 9 cases; and over 201 in 9 cases. Only 14.5 per cent required over 200 days of treatment. In 71 per cent of the cases 3 months of treatment sufficed.

In the evaluation of the results to date, that is, 9 months after the onset, only those patients are considered to have attained complete, normal recovery who are performing all activities at least as well as they did before the onset of the disease, and in which no questionable weakness or spasm could be demonstrated after several observations. When a questionable weakness

or limp or spasm was found or suspected, those patients were listed as "border." The patients so listed, we feel, will have complete, normal recoveries in a period of a few months.

When definite weakness or muscle spasm is present, these cases are rated as "good" or "fair," depending on the degree of weakness, and when very marked weakness or actual paralysis of 1 or more muscles is observed, these are rated as "poor." When only 1 muscle is paralyzed, the case is reported as a poor anatomic result, the same as a case with paralysis of several muscles. In the functional evaluation, those patients with weakness, paralysis, or just "border" are rated according to how well they can use the affected muscles or limbs.

By our definition of "border" cases, all of these patients have excellent functional results. In considering the cases with evident paralysis or weakness, we may have a patient with a paralyzed anterior tibial muscle who walks well without a limp, and another patient with no paralysis but weakness or spasm who may walk poorly.

The results are listed in table 1. In 24 cases involving 1 unit, there were 9 complete normal recoveries, with 2 "border" cases, 3 good results, 4 fair, and 4 with definite paralysis or poor results. Two patients were not followed.

The rest of the table can be analyzed in the same manner, and in totaling we find 18 patients completely recovered of the 55 followed. Nineteen of the 55 patients had a residual paralysis, but only 7 had a poor functional result. One patient is still in a respirator.

The next group of patients were treated with "Kenny technic" and prostigmine and numbered 41, and 34 were followed throughout. Ten patients had 1-unit involvement, 18 had 2 units, 3 had 3 units, 5 had 4 units, 2 had 5 units, 1 had 6 units, and 2 had 7 units. The involvement included 31 right legs, 30 left legs, 7 right arms, 6 left arms, 4 abdomens, 10 necks, 8 backs, and 1 thorax.

The number of days of treatment was 25 or less in 10 cases, 26 to 50 in 6 cases, 51 to 100

in 12 cases, 101 to 200 in 7 cases, and over 201 in 6 cases. Again, as in the other group, 14.5 per cent required over 200 days of hospitalization, and in 69 per cent 3 months or less of treatment sufficed.

The results in this group are shown in table 1 also. There were 7 complete recoveries out of the 34 patients followed or about 20 per cent. The other group, with Kenny treatment alone, had 32 per cent complete, normal recovery. In this group there were fewer definite paralyses, 20 per cent as opposed to 35 per cent in the Kenny-treated. The functional poor results were 3 or 9 per cent, while in the Kenny alone they were 12 per cent. One patient had a 7-unit involvement and was in a respirator.

Five patients were treated with prostigmine; only 2 were followed. Both of these recovered completely, 1 in 60 days and 1 in 120 days. One had all 4 extremities involved, and 1 had a leg involvement (see table 1).

It is very difficult from our figures to evaluate the use of prostigmine. Several cases were started on it with the hope of using it exclusively, and some remained so spastic that Kenny treatment was supplemented. The 2 patients we report have responded well. Our general impression of prostigmine was that it may be beneficial in relieving spasm that fails to respond to hot fomentations.

Four patients received ultraviolet blood irradiation followed by Kenny treatment. All 4 patients had involvement of the legs, 3 both legs, and 1 only 1 leg. Only 3 patients were followed, and all 3 made complete normal recoveries in an average of 180 days of treatment.

One patient with involvement of both legs received nothing but good nursing care. We were unable to follow this patient, and the outcome is unknown.

CASES HAVING BULBAR, PONTINE, OR CEREBRAL INVOLVEMENT

In order to simplify the presentation of our cases we have included in this group all those cases with involvement of the pons, the medulla,

and the cortex. It is very difficult to localize the symptoms in many of these cases because of the diffuse involvement. In only 4 of the 38 did we find seventh nerve involvement as evidenced by facial paralysis. The remaining had definite bulbar involvement.

Since the patients with bulbar involvement represent a special problem in the acute stage of the disease, they are being considered separately. The bulbar symptoms were in most cases treated primarily, especially if there was any pharyngeal involvement. In those cases it was our policy to give special nursing care with an aspirator at the bedside with the foot of the bed elevated, feeding by mouth being avoided until the patient was able to swallow.

TABLE 3
*Types of Treatment in Bulbar Cases**

AGENT	NO. OF CASES
Glucose and Saline Injections.....	19
Prostigmine Injections.....	18
Sedation.....	15
U.B.I.....	10
Plasma Infusions.....	9
Thiamine Chloride.....	6
Atropine.....	4
Sulfonamides.....	4
Blood Transfusions.....	3
Respirator.....	2
Penicillin.....	1

* An aspirator was kept at the bedside of all patients and used to keep the airway free of mucus.

Table 3 shows the different forms of treatment used in the bulbar cases; in general it was empirical and symptomatic. Glucose and saline solutions were used intravenously for most of the patients having swallowing difficulty to replace the fluids by mouth.

Blood and plasma were given in certain cases, and it was the general impression of those following the cases that these were often followed by reactions of varying severity, some quite severe.

Some observers have felt that sulfonamide drugs make poliomyelitis patients worse. In

the few in which it was used in our series that did not seem to be true. Vitamin B₁ or the complex seemed to have little effect. Atropine did little in suppressing secretions in the pharynx.

At the height of the epidemic we were getting a great many bulbar cases of a severe type; many were very severe, even moribund. Of the first 14 patients with bulbar involvement admitted, 5 died. A summary of the deaths in this group is shown in table 4. Four of these patients died within 24 hours after admission; 2 were put into respirators and showed aspiration of secretion at autopsy. They had been ill 5 to 10 days before admission. The fifth death occurred after 3 days of treatment.

TABLE 4
Bulbar Deaths

DAYS OF ONSET BEFORE ADMISSION	TREATMENT	HOSPITAL DAYS BEFORE DEATH
1	Plasma—Prostigmine—Glucose Solution—Sedation—U.B.I.—Amigen—Ascorbic Acid	9
5	Respirator	1
7	Blood, Vitamin B ₁	3
9	Respirator, Glucose Solution, Vitamin B ₁	$\frac{1}{2}$
6	Glucose Solution, Sedation, Vitamin B ₁	1
10	Plasma Infusion, Prostigmine, Glucose Solution, Atropine	1

It was at this time that ultraviolet irradiation of blood was started with the help of Dr. G. J. P. Barger of the Georgetown Hospital. It was used on the next 11 bulbar cases, 1 death occurring in this group.

Thirteen patients with bulbar involvement were later admitted, none of which received blood irradiation, and there were no deaths. Three of them had pontine involvement rather than bulbar. This observation is made because many of us felt that ultraviolet irradiation seemed to combat the toxicity of many of the cases, although in bulbar cases there are often sudden changes. It was felt that in toxic bulbar cases, especially those with encephalitic signs, the use of ultraviolet irradiated blood deserves consideration and further trial. We

feel fairly certain, however, that the early use of ultraviolet irradiation does not influence the development of spinal paralysis.

In considering the bulbar symptoms alone, of the 38 bulbar-pontine-central cases which represented 19 per cent of our total, there were 6 deaths, giving a mortality of 16 per cent for the group; and, since they constituted our total deaths, they are responsible for the mortality of 2.9 per cent for the entire group of poliomyelitis cases.

TABLE 5

Results in Cases with Bulbar and Cranial-nerve Involvement
Bulbar and/or cranial-nerve involvement

C.N.R.	RESIDUAL	DIED	NOT FOLLOWED
20	5	6	7

Added spinal involvement												
INVOLVEMENT IN UNITS	NO. OF CASES	NO. OF CASES FOL- LOWED	NO. OF DEATHS	C.N.R.	ANATOMIC RESULTS				FUNCTIONAL RESULTS			
					B	G	F	P	E	G	F	P
1	5	4	0	1	0	2	1	0	1	2	0	0
2	8	6	1	5	0	0	0	0	0	0	0	0
3	5	4	0	2	1	0	0	1	1	1	0	0
4	1	0	0	0	0	0	0	1	0	0	1	0
5	1	0	0	0	0	0	1	0	0	1	0	0
6	1	0	0	0	0	0	0	0	0	0	0	0
7	5	3	2	0	0	0	0	1	0	0	0	1
Total . . .	26	17	6	8	1	2	2	3	2	4	1	1

Explanation:
Unit—A unit equals 1 limb or portion of the body
C.N.R.—Complete Normal Recovery
B—Border Case
G—Good Result
F—Fair Result
P—Poor Result
E—Excellent Result

There were 7 patients that we were unable to follow and 20 patients that we considered to have had complete, normal recoveries as far as bulbar symptoms were concerned, these symptoms clearing up in less than 3 weeks. There were 5 patients with residuals, either a facial or a pharyngeal weakness. These residuals are still present after 8 or 9 months.

Spinal involvement occurred in over two thirds

of our bulbar-pontine-central cases. The same percentage of bulbar cases have spinal paralysis as the non-bulbar cases (68 per cent). Of our 38 bulbar cases, there were 12 without spinal paralysis (32 per cent).

The spinal involvement is shown in table 5 in the same manner as before, and of the 17 patients followed, 8 had a complete normal recovery. There were 3 with residual paralyses and 1 with poor function.

In order to summarize our results up to this point, we must add those cases in table 5 to those in table 1 for the summary as shown in table 6.

TABLE 6

Composite Summary

	NO. OF PA- TIENTS AD- MITTED	NO. OF PA- TIENTS FOL- LOWED	COM- PLETE RECOV- ERY	ANATOMI- CALLY POOR RESULTS	FUNC- TION- ALLY POOR RE- SULTS
Non-Paralytic	54	41	54	0	0
Paralytic (Spinal)	113	94	28	26	10
Bulbar	38	27	28	3	1
Total	205	162	110 or 70%	29 or 18%	11 or 7%

Of the 205 cases admitted, we have been fortunate enough to follow for almost a year 162 cases. This represents a preliminary report, because many of the patients are still under treatment. Of all the cases admitted, 70 per cent are entirely well. Eighteen per cent have a residual paralysis, but only 11 per cent have poor function. Since function is the important point to the patient, this percentage of poor function should remain under 10 per cent. About 12 per cent have varying degrees of weakness which will, in all probability, so improve that by next year the number of cases of complete, normal recovery will amount to 80 per cent and the number with residual paralysis will constitute about 20 per cent.

The Committee on Poliomyelitis wishes to express its appreciation to Lt. A. N. Conte, M.C., A.U.S., and to Dr. Dom Judge for great help in analyzing from the charts the statistical data included in this report.

ACUTE POLIOMYELITIS

A Study of the Patients Seen in the Gallinger Municipal Hospital during 1944*

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WITH the beginning of summer it is again time to have acute poliomyelitis constantly in mind. According to the epidemiologic pattern of the disease, we do not anticipate another epidemic in this area this season. However, there certainly will be some cases. On this account it is our purpose to review the experiences at Gallinger Municipal Hospital in the poliomyelitis epidemic of 1944 and by so doing to rekindle awareness of poliomyelitis. Perhaps some benefit may result from consolidating the knowledge we gained from the many cases seen last year.

For a proper understanding of the figures it must be clearly remembered that at Gallinger Hospital we had both adults and children with poliomyelitis, while at Children's Hospital only children were admitted. In addition to District residents of any age, Gallinger accepted non-resident adults, and Children's Hospital accepted both resident and non-resident children. It is only by studying the combined statistics that an accurate concept of the size of the epidemic in this vicinity and the relationship of incidence of poliomyelitis to age groups can be obtained. Even so, as bears on this and adjacent communities, a small discrepancy on epidemic statistics must remain, since a few patients were not hospitalized at all and a few were hospitalized in other institutions.

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† Dr. Feffer made his contribution to this study before entering the Army of the United States.

As the 1944 epidemic progressed we diagnosed 105 cases of the disease. In retrospect, 9 cases were decided to be of doubtful diagnosis. The 9 so eliminated from the group of positively diagnosed poliomyelitis will be discussed at the end of the paper after we have discussed in detail the 96 definite cases of poliomyelitis.

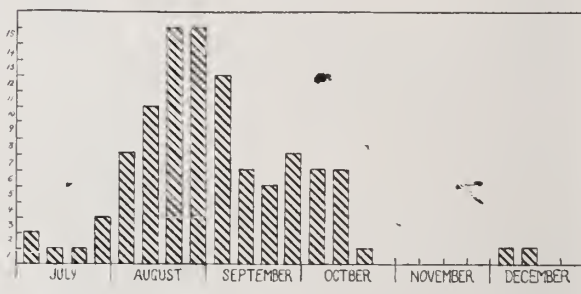


CHART 1. Incidence of 96 cases of poliomyelitis based on date of onset (months are divided into quarterly periods).

Chart 1 represents the time of occurrence of the cases based on the date of onset and enumerated by quarter months. The largest number of cases per unit of time developed in the latter half of August and the first quarter of September. There was a plateau of new cases from then until the middle of October, following which the drop was abrupt with only 3 patients between October 15 and the middle of December, with none in November.

Most of the patients were admitted to the hospital within a few days following the onset of poliomyelitis. They remained in the hospital for widely different lengths of time. Forty-eight patients were discharged within 6 weeks,

and accumulatively 77 were discharged within 3 months. There are 3 patients still in the hospital, their numbers of hospital days being 218, 262 and 269 as of June 1, 1945. Several others of our patients are in other hospitals up to the present, having been transferred from here for various reasons.

The ages of the patients ranged from 6 months to 51 years. Chart 2 shows this age incidence in detail. By comparing the above with the similar data from Children's Hospital a fair

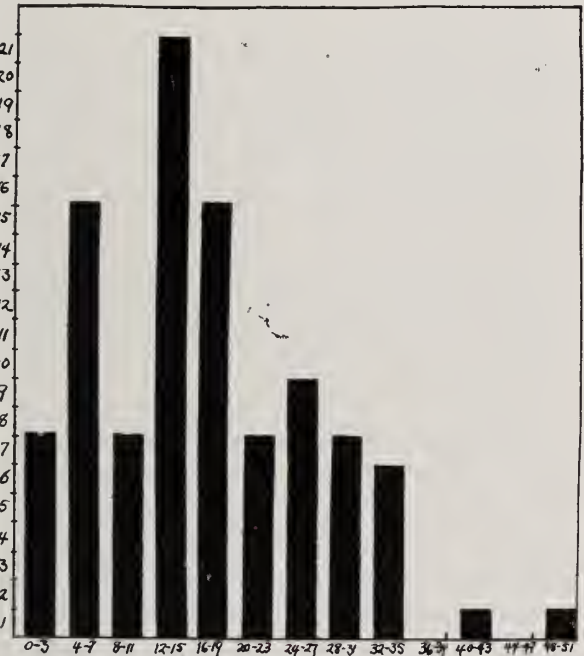


CHART 2. Distribution of cases by age in years, divided into groups inclusive of four years each

impression can be gained of the age incidence of this disease; our group when reviewed alone gives a very inaccurate picture since it does not show the relatively high poliomyelitis rate in childhood. Their group when reviewed alone also gives an inaccurate picture, because it does not show the amount of poliomyelitis seen in adolescence and adult life.

We were unable to see any relationship between sex and color in the incidence of poliomyelitis. There was 1 instance of multiple incidence of poliomyelitis in siblings.

SYMPTOMATOLOGY

The chief complaints obtained from the histories on admission to the hospital were as follows:

Headache.....	74
Nausea and/or vomiting.....	59
Stiff neck.....	51
Weakness and/or paralysis.....	48
Fever.....	41
Peripheral pain.....	26
Backache.....	24
Upper respiratory infection.....	17
Dysphagia.....	13
Abdominal pain.....	11
Voice change.....	10
Respiratory embarrassment.....	5
Chills.....	5
Urinary retention.....	3
Paresthesias.....	2

There were rare miscellaneous complaints of: anorexia, delirium, photophobia, taste change, stupor, lethargy, lachrimation, dizziness and epistaxis. In the case of 1 of the patients listed above as complaining of difficulty in swallowing, the symptom was due to pharyngitis rather than pharyngeal paralysis. One patient gave a history of tonsillectomy within the possible incubation period of poliomyelitis. The tonsillectomy preceded the poliomyelitis by 3 weeks. She had the bulbar type of the disease.

In dealing with physical signs we have summarized them inclusively from the time when a patient was first seen until the fullest development of the picture. In the vast majority of the cases these observations were made and completed during the acute stage of illness. However, there were a few exceptions to this generalization, since there were 3 paralyzed patients who came in with a diagnosis of "chronic" poliomyelitis after the acute phase of illness had passed and 3 patients whose weaknesses became manifest or more marked during the chronic stage when too much activity was attempted. Since none of these patients alter the validity of the figures, the entire group of 96 patients will be considered together.

Since spasm of the neck, back and hamstrings are of definite diagnostic value, we have shown in chart 3 the numbers of patients in whom all 3 were present with a comment on the evaluation of the absence of these signs where this absence raised some diagnostic question.

We will not comment on the groups in which spasm of the neck was present, regardless of what other sites of spasm were missing, because in the patients having a stiff neck we did not find the

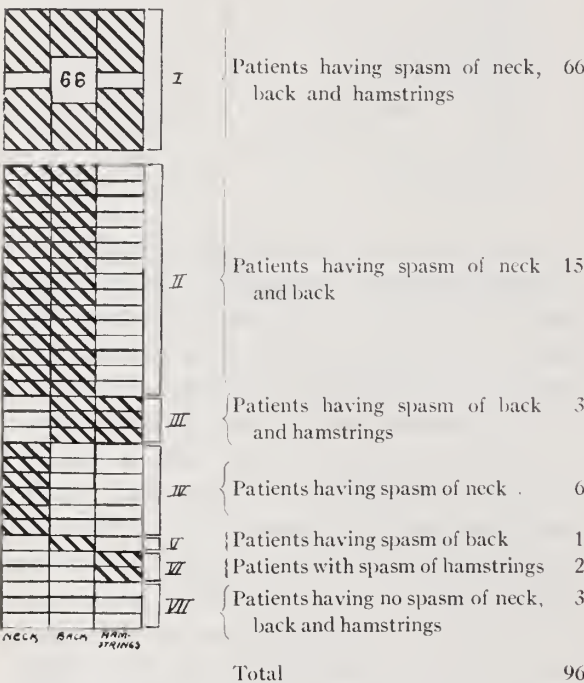


CHART 3. Distribution of spasm of neck, back and hamstrings

absence of back and/or hamstring spasm a source of diagnostic difficulty. However, considering neck spasm an almost imperative finding for the diagnosis of poliomyelitis, we feel that any diagnosis of that disease without stiff neck requires particular justification. There were 9 patients without neck spasm. (These are found in groups III, V, VI and VII of chart 3.) Of the 9, 6 had paralysis, and the other 3, having no paralysis, had histories, clinical courses and spinal fluid findings characteristic of poliomyelitis.

There were 70, or 73 per cent, with some

degree of paralysis. This left 26 patients, or 27 per cent, as non-paralytic. We have classified the paralytic group according to the part of the nervous system involved to produce the given paralysis. This is shown in table 1.

TABLE 1
Classification of Patients with Paralytic Poliomyelitis Depending on Site of Central Nervous System Involvement

Pure Spinal*	49
Pure Cranial	7
Bulbar*	3
Pontine*	3
Bulbar and Pontine	1
Mixed Cranial and Spinal	14
Bulbar and Spinal	7
Bulbar and Spinal with Encephalitis	4
Bulbar, Pontine and Spinal	1
Pontine and Spinal	2
Total	70

* "Spinal" denotes any involvement below the pharynx, including the neck when no higher involvement is present; "bulbar" denotes involvement of the palate and pharynx; "pontine" refers to involvement of the facial muscles.

There is a distinction to be made between two main groups of the bulbar poliomyelitis patients. In the bulbar and spinal group with encephalitis the order of development of paralysis is important. There were 4 such patients. In all the paralysis was of the ascending type. The peripheral respiratory paralyses from spinal cord involvement were conspicuously present before higher involvement appeared. The bulbar involvement and the encephalitis developed after the patients were in respirators. As the paralysis ascended these patients developed higher fever and increasing tachycardia. In the other combinations of bulbar and spinal poliomyelitis all involvement was more or less simultaneous (the bulbar complaints being manifestly present on admission), and in at least 2 cases the spinal involvement appeared considerably later than the bulbar.

In chart 4 we have shown the distribution of paralysis in each combination seen, itemized against the number of patients having any combination.

As a general rule in poliomyelitis thoracic (high spinal) involvement usually is associated with paralysis of the arms, bladder involvement with paralysis of the legs, and cranial involvement with no spinal involvement (except in the rapid, fulminating, ascending type of poliomyelitis). The breakdown of our figures in the majority of cases does substantiate these generalities, but

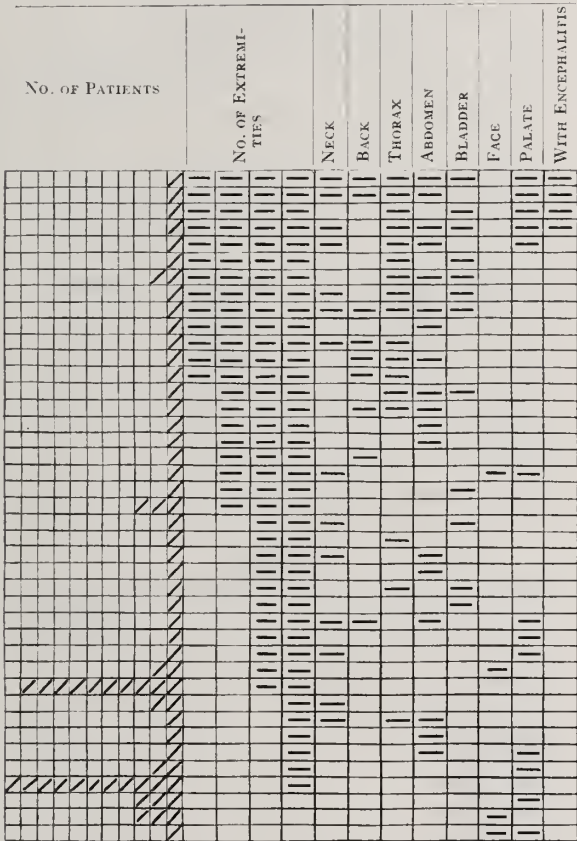


CHART 4. Showing the distribution and combinations of paralyzes in the 70 cases of poliomyelitis with paralysis.

there were 2 patients with thoracic involvement and 1 with bladder involvement without the corresponding extremities being involved. When all 4 extremities were paralyzed the thorax and bladder were affected. Table 2 shows the various patterns in detail.

A review of the temperature records of these patients was interesting. The majority of patients had either low-grade fevers or only moderate ones. Out of the 96 only 19 had fevers of

103° F. or higher. At the other extreme, the temperatures of 25 patients were not above 99.8° F. (rectal). However, since only 7 of these 25 were admitted within the first 4 days of the illness, it cannot be said with any accuracy whether or not the remaining 18 ran an afebrile course earlier in the disease. The duration of fever, from date of onset, varied from 1 day to 19 days. In most patients the temperature was back to normal within 1 week. The fever had subsided within 2 weeks except in 3 cases, in 2 of which it lasted 15 days and in the third, 19 days. Table 3 shows the highest temperature recorded for each patient.

TABLE 2
Relation of Bladder, Thoracic and Cranial Nerve Paralysis to Paralyzes of the Arms and Legs

	4 EXT.	2A, 1L*	1A, 2L	1A, 1L	2A, 0L	1A, 0L	0A, 1L	0A, 2L	0A, 0L
Cranial	5	0	1	2	1	2	1	2	7
Thoracic	13	0	2	0	1	0	1	1	0
Bladder	8	1	1	1	1	0	0	1	0

* "A" indicates Arms; "L" indicates Legs.

TABLE 3
Highest Recorded Temperature for Patients with Poliomyelitis

TEMPERATURE*	NO. PATIENTS
Normal to 99.8	25
100-100.8	14
101-101.8	22
102-102.8	16
103-103.8	7
104-104.8	6
105-105.8	5
106-106.8	1
Total	96

* Rectal temperature recorded in degrees Fahrenheit.

The laboratory data of significance were spinal fluid examinations and white blood cell counts. The cerebrospinal fluid findings will be discussed first. Seventy-eight or 81.2 per cent of the patients had a pleocytosis, 9 or 9.4 per cent had spinal fluid cell counts within normal limits and 9 or 9.4 per cent have no record of spinal fluid

examinations. Of the patients having normal spinal fluid cell counts, 7 had definite paralysis and 2 had characteristic spasm and quantitative spinal fluid proteins of 64 and 163 mg. per cent respectively. Therefore even in the absence of increased cells these patients were diagnosed poliomyelitis. Of the 9 having no record of spinal fluid examinations, 4 had extensive paralysis and were too sick for a spinal tap. They were placed directly in respirators. Two paralytics were admitted considerably beyond the time of acute illness and therefore were not tapped. In the remaining 3 the counts were omitted because of technical difficulties. The detailed enumeration of spinal fluid cell counts is listed in table 4.

TABLE 4

Spinal Fluid White Cell Counts for Patients with Poliomyelitis

CELL COUNTS	NO. PATIENTS	
0-10 W.B.C.....	9	9.4%
11- 20 W.B.C.....	6	
21- 50 W.B.C.....	14	
51-100 W.B.C.....	15	81.2%
101-500 W.B.C.....	38	
501 and over (520, 690, 800, 850, 1,000).....	5	
No Record.....	9	9.4%
Total.....	96	

There was a uniform predominance of lymphocytes in the spinal fluid differential counts. Occasionally there was a transient predominance of polymorphonuclear leukocytes very early in the course of the disease, but repeated spinal taps after a day or two invariably revealed a reversal in this relation with a resulting predominance of lymphocytes.

The spinal fluid quantitative protein reports produced two disappointments. 1. Taking 45 mg. per cent as the upper limit of normal, there were 16 cases with normal cerebrospinal fluid proteins. In several cases there is an obvious explanation for these normal findings in that a conspicuously sufficient time since the onset of the illness had elapsed for a return to normal, but

in most of the 16 instances it appears that the increase of protein, if present at all, was very transient. These 16 cases all had reasonable diagnoses of poliomyelitis. Since they overlap with all of the cases listed, and if necessary explained, under the discussion of cerebrospinal

TABLE 5

Spinal Fluid Quantitative Proteins for Patients with Poliomyelitis

NO. PATIENTS	QUANTITATIVE PROTEINS*
32	No Record
16	Normal (45 or below)
6	25 or below
10	45 or below
48	Increased (46 or above)
19	46- 70
8	71-100
17	101-200
4	201-250
Total: 96	

* Quantitative proteins in mg. per cent.

TABLE 6

Total White Blood Cell Counts for Patients with Poliomyelitis

CELL COUNTS	NO. PATIENTS
No Report.....	22
3,500- 4,000.....	2
4,100- 6,000.....	16
6,100- 8,000.....	21
8,100-10,000.....	23
10,100-12,000.....	6
12,100-15,000.....	4
15,100-20,000.....	2
Total.....	96

fluid cell counts, no further comment will be made here. 2. The correlation between the Pandy's test and the quantitative proteins was utterly unreliable and erratic. Our original belief was that the lack of correlation depended on technical errors, but now we do not believe this to be the cause, since published work on the subject concludes that the Pandy's test is unsat-

isfactory and essentially useless for clinical application.¹ The facts are stated in table 5.

White blood cell counts were fairly uniform. They were mostly either normal or only slightly increased. Table 6 reveals the details in this connection.

DIFFERENTIAL DIAGNOSIS

Now we can turn to the most absorbing and challenging phase of the poliomyelitis epidemic, the question of differential diagnosis. As was said at the beginning of this paper, we originally diagnosed 105 cases of poliomyelitis. Since then we have eliminated 9 cases. These 9 and many others seen in the course of the summer and fall were the fascinating problems. Here, as all over the epidemic areas of the United States, a great many people were poliomyelitis suspects. In the majority of these cases the diagnosis of poliomyelitis could be put aside after a careful history, physical examination and perhaps a spinal tap were obtained. Repeatedly, however, we encountered difficult and intriguing cases for differentiation.

1. *Patients having spinal fluid changes.* We had patients in whom the following conditions had to be differentiated from poliomyelitis: tuberculous meningitis, purulent meningitis, central nervous system syphilis, Guillain-Barré syndrome, Weil's disease, and lymphocytic choriomeningitis. Except for the last two of these the correct diagnosis became evident after several days of observation and after repeated spinal taps. The patient with Weil's disease was considered a poliomyelitis patient for several days on the basis of neck, back and hamstring spasm and cerebrospinal fluid changes. We corrected the diagnosis on this when jaundice was observed and laboratory tests for Weil's disease were found to be positive. As regards lymphocytic choriomeningitis, the differential diagnosis from non-paralytic poliomyelitis might well be impossible without laboratory tests. The patient here who raised the problem, though, had a definite paralysis of the bulbar type. Because of

vague symptoms suggestive of a former patient with lymphocytic choriomeningitis, a series of bloods were sent to the National Institute of Health for animal protection studies against this disease. Surprisingly, the reports showed an increasing protection. We have kept this patient in our list of definite poliomyelitis patients because her illness occurred during the epidemic, her cerebrospinal fluid findings were characteristic, and she had the typical distribution of spasm and marked bulbar paralysis. It is possible that these findings were caused by the virus of lymphocytic choriomeningitis, but we are by no means convinced that this is the case.

2. *Intracranial lesions.* We studied patients as possible cases of poliomyelitis who had a subdural hematoma and a brain abscess. In both the doubt arose from the presence of headache and vomiting in the middle of a poliomyelitis epidemic. In each case poliomyelitis was ruled out by cross-examination in history-taking, neurologic examination, and negative spinal fluids.

3. *Diseases producing pseudoparalysis secondary to pain.* The 3 patients producing this confusion had, respectively, gonorrheal arthritis, acute osteomyelitis, and secondary syphilis. The arthritis and osteomyelitis were soon correctly diagnosed by repeated physical examinations and the clinical course. The patient with secondary syphilis was more of a problem because she repeatedly revealed the same pattern of marked weakness of both legs accompanied by poorly localized leg pain. After several days her Kahn test was reported positive, and almost simultaneously she developed a widespread rash. Prompt recovery from all symptoms followed antiluetic therapy.

4. *Other infectious diseases.* Several patients were seen with influenza. Each of these remained a problem for a few days because of generalized weakness, peripheral muscle pains, transient muscle stiffness, fever curves and blood counts similar to those seen in poliomyelitis. True, they all had negative cerebrospinal fluids

but it was only by the passage of time that we could properly evaluate the entire picture and discard the possibility of poliomyelitis. A patient finally diagnosed as having rabies was a questionable candidate for admission to isolation as having poliomyelitis because of his difficulty in swallowing. The history of a dogbite and the course of events settled the diagnosis. A woman seen with a stiff neck and headache turned out to have acute myofascitis and not poliomyelitis after physical examination revealed that her headache was a tender sore scalp and her neck was free in anteroposterior motion but rigid in attempted lateral motion.

5. *Emotional instability producing symptoms.* As is universally true in any epidemic of poliomyelitis, there was widespread fear of the disease during this one. Many emotionally disturbed patients were seen who were convinced that they had "infantile paralysis." Their real or imagined symptoms covered a wide range. However, these people responded well to repeated reassurance. The chief need of many of them was some explanation of the disease. When this was given and their understanding increased their anxiety was relieved. We saw 1 case of hysteria during the course of the epidemic. The patient was a young woman with paralysis and anesthesia of the forearm, wrist and hand. The anesthesia was of glove distribution. Both her anesthesia and the paralysis disappeared after a long talk with her private physician.

The 9 patients eliminated from the original total diagnosed as poliomyelitis continue to be unsolved problems. Three were patients in which the subsequent course of events made the earlier diagnosis of poliomyelitis extremely unlikely. One 13-year-old colored girl with history, physical findings (including weakness) and laboratory work typical of poliomyelitis, did well for about 1 month with a decrease in her weakness. She was walking without a limp. After this, however, her condition developed into a bizarre picture with unusual neurologic signs and movements suggestive of chorea. She has been seen

by numerous consultants. No recent final diagnosis has been made, but the diagnosis of poliomyelitis on her has fallen into disrepute. Another was an 11-year-old white girl who injured her left leg 3 weeks before admission to the hospital. The leg had given her persistent pain with a limp. She also had headache, nausea, vomiting and some fever; her cerebrospinal fluid cell count was normal, and the quantitative protein was not done. She had demonstrable weakness of both her left arm and leg. There seemed no doubt that this child had had poliomyelitis until months later when it was known that her left hip joint became extremely rigid, "practically ankylosed," according to one description. A roentgenogram of the hip has not explained the signs. Although the cause for her trouble is not known, we do not feel that poliomyelitis can be held responsible. The third was a 5½-month-old colored boy who, during the course of a diarrheal illness for which he was already hospitalized, developed a secondary fever and signs of meningeal irritation. His spinal fluid had 380 cells, with 90 per cent lymphocytes, and later 134 mg. per cent of protein. He had no weakness but spasm of his hamstrings and back. The spasm became much worse after this acute illness and had the character of that seen in a congenital spastic. We argued considerably about this infant, and finally the orthopedic side won, leaving the pediatric representation to concede that the diagnosis of poliomyelitis was doubtful.

Next, there were 2 cases in which poliomyelitis seemed to be only a remote possibility in spite of the fact that we have no other diagnosis to offer. One was a 6-year-old colored boy who was very acutely ill with a persistently high fever up to 105° F., headache, nausea and vomiting, and abdominal pain. He had the meningeal pattern of spasm but no weakness. His spinal fluid was entirely normal, and his white blood cell count was 20,000. One examiner thought he had suggestive signs of pneumonia. After several days his fever disappeared by crisis; he made an uneventful recovery and was discharged in good condi-

tion. It seems likely that his spasm was a meningismus secondary to some pyogenic infection, possibly lobar pneumonia. The other was a 19-year-old white girl who had had contact with two or three known poliomyelitis patients during their acute illness. She complained of headache, respiratory infection, and muscle pain. She had spasm of her back and hamstrings. She had no fever, a normal spinal fluid, and a normal blood count. Within 10 or 12 days she was entirely flexible in all muscles and was discharged on the fourteenth day as being entirely well. Either an upper respiratory infection or a mild influenza may have caused her slight illness.

The following 4 patients may well have had poliomyelitis, but we have no positive evidence of this. Three were boys, aged 6, 7 and 15 years; the fourth was an 18-year-old girl. They had histories entirely compatible with poliomyelitis, with neck, back and hamstring spasm and some fever. None of them had any weakness, and none of them had spinal fluid changes. They all made steady, complete recoveries. They all may have had poliomyelitis, but we have no certain evidence to settle the question.

Before leaving the descriptive and diagnostic phase of this subject, it is interesting to note and comment briefly on one coincidental condition which was seen several times in the course of the epidemic. We had 30 women from 17 to 45 years of age. Of these 5, or 16.7 per cent, were pregnant. This is particularly interesting in view of already existing suspicions that there may be some relationship between the incidence of poliomyelitis and the presence of pregnancy. Two delivered full term, perfectly normal babies, 1 had a small premature infant who survived only a few hours, 1 had Rh negative blood and aborted spontaneously, and we do not know what happened to the fifth.

Also there were two complications of the disease that occurred often enough to warrant mention. Several of the patients with widespread paralysis developed hypertension. We are not prepared to make any comment on this, but be-

lieve it a subject worth careful study. Also 2 patients developed thrombophlebitis.

TREATMENT

The treatment of patients with poliomyelitis soon settled into a few general routines, subject to variation depending on the individual and his particular problems. From a medical viewpoint the only specific therapy was for patients having high spinal involvement with respiratory distress, bulbar involvement, or urinary bladder involvement. Any other medical treatment was according to symptoms and complications as they developed. From the orthopedic viewpoint we abandoned the so-called "orthodox" method entirely, using Sister Kenny's treatment throughout.

We had 18 patients with more or less involvement of the respiratory muscles. Of these, 1 patient was signed out within a few hours of admission, 4 patients had no respiratory embarrassment at all, and 13 had sufficient involvement to cause actual respiratory difficulty. Of these 13, 10 were placed in respirators, and the remaining 3 received intensive, constantly repeated hot packs to the entire chest and abdomen. Two of these patients did very well, recovering the adequate power of their thoracic muscles for efficient respiration within several days. The third died within a few hours. Her story is unique, and to this day we do not know if a respirator might have saved her or, at least, prolonged her life. She is unique in that her periods of dyspnea could apparently be brought to an end by emphatic and reiterated assurance and reassurance. When last seen by a physician it was after one of these episodes, and she appeared to be breathing satisfactorily. Her death occurred very suddenly before a doctor could reach her. It seems possible that her terminal respiratory failure may have been central in origin. The 10 who were put in respirators obtained immediate and vital relief. We feel that muscle spasm played no part in their respiratory distress and that their only hope for survival was in the use of respirators on account

of the severity of their involvement. Four of these patients died within a week of admission to the hospital. These 4 were the patients who comprised the group of spinobulbar encephalitis mentioned earlier under the classification of paralyses. Two others of these patients who were in respirators expired several months later, both from unknown causes. One was not autopsied. The other had been transferred to a teaching hospital where she died and was autopsied. No cause for her sudden death was found, but it was reported that she had microscopic evidence of very active infection still present in her spinal cord. This leaves 4 living patients of the original 10 who were put in respirators, 3 of whom are entirely independent of their respirators and have been for months. The fourth patient still feels that she must use hers at night. The freeing of adolescents and adults from respirators was in itself quite a therapeutic problem. They developed an emotional as well as a physical reliance on this sure method of breathing, and were afraid to relinquish the prop. We did not force any patient to come out of the respirator. Having assured ourselves that this aid was no longer necessary we urged, persuaded, and explained until the patients finally had enough confidence to undertake a trial out of the respirator. From this point on each gained respiratory independence at a rate of speed depending on his personal capacity.

Several of the patients who were in the respirators developed high secondary fevers. We gave sulfonamides to them without definite knowledge of the cause of the fevers. The most probable cause in all cases was a bronchopneumonia secondary to aspiration and unchanged position. X-ray and adequate physical examinations were impossible. Even so it seemed better to use sulfonamides than let possible pneumonia go untreated.

Our medical routine for bulbar poliomyelitis was very strict and was very sternly enforced. The patients were treated according to the plan and rationale outlined some years ago by Wilson,²

who showed that there are 3 types of respiratory failure in poliomyelitis. One is that type seen in high spinal involvement in which paralysis of the respiratory muscles exists. The second is that seen in bulbar poliomyelitis with paralysis of deglutition. These patients exhaust themselves attempting to prevent the aspiration of pharyngeal secretions while breathing. In such patients it is dangerous to use a respirator. If used it is apt to do great and irreparable damage by the aspiration of material into the bronchial tree and lungs. The ideal treatment for these patients consists of maintaining a clear airway. The third is failure of central origin due to involvement of the respiratory center. This may be precipitated by the train of events possibly following a choking episode in the bulbar type of poliomyelitis. As described by Wilson, some of these patients may, after choking over their own secretions or over food or vomitus, develop a devastating and rapidly fatal course in which they have irregular respirations, a rapidly increasing pulse rate, and finally death from either respiratory arrest or circulatory collapse or both. The explanation for these disastrous developments is thought to be that during an attack of coughing and choking a period of anoxia supervenes with a resultant increased cerebral edema and then abnormal function of the central respiratory mechanism and depression of the vagus nerve. In this type of respiratory failure in which the patient's respirations are irregular with reference to rate, rhythm and depth, a respirator is useless and may be harmful. The respirator cannot be synchronized with respiratory irregularities resulting from impulses from the central nervous system. Consequently there would be complete respiratory chaos. Based on these reasons, all of our bulbar poliomyelitis patients, no matter how mild their involvement, were treated as follows: (1) They were given nothing at all by mouth. Feeding by stomach tube was not resorted to because the passage of the tube might induce gagging and choking; or food in the stomach might produce vomiting and

consequent aspiration of vomitus. (2) An aspirating apparatus was constantly at the bedside and used as necessary to remove secretions from the mouth and pharynx. (3) A private duty nurse was always in attendance. (4) Pillows were forbidden, and the foot of the bed was elevated to facilitate postural drainage. (5) Parenteral solutions were used for feeding. At the very end of the acute period of illness the rectal route was employed. These measures were continued until the patient had been entirely afebrile for at least 48 hours, and then, depending on the general condition of the patient, small sips of water were tried by mouth. This trial always took place when a physician was present. If deemed a success, clear fluids were allowed freely by mouth. Only 1 patient had so much difficulty on this trial that her period of nothing by mouth was continued for another 48 hours. Once the febrile period of disease was over and so the acute illness judged passed, we were not much concerned about the hazard of an occasional choking episode, because at this later stage the unfortunate sequence of events described above usually does not occur. If patients had been unable to swallow at this point, they would have been fed by gavage.

There were 12 patients who had bulbar poliomyelitis without encephalitis. These patients were treated by this régime with ultimate recovery in all instances.

In one situation the management of patients with bulbar involvement becomes a matter of choosing between the lesser of two evils. When patients have both thoracic and bulbar muscle involvement they may require a respirator as their only chance of survival. We had 5 such patients for whom we used the respirator in combination with the bulbar routine outlined above. Four of the 5 also had poliomyelitis. These 4 patients were mentioned previously. They were the ones with an ascending type of paralysis in which the bulbar and then the encephalic involvement followed the spinal involvement by some time, with the high fever and the

increasing tachycardia. The 1 who had no encephalic involvement was included in the 12 noted above who lived.

Our medical approach to urinary bladder involvement was the use of subcutaneous prostigmine. If this failed, we catheterized the patients. There were 13 patients with urinary retention. Three voided following the use of prostigmine, and 10 required catheterization.

With 2 deliberate exceptions we used the Kenny treatment throughout the epidemic on all patients in all phases of the disease. The first exception was the bulbar poliomyelitis patients. Sister Kenny recommended a program of mouth-feeding, but as already stated our patients received nothing by mouth. These patients were given Kenny treatment for spasm or coincidental paralyses. The second exception was in dealing with patients having severe thoracic paralysis. We put these patients in respirators instead of using hot packs to their chests, because we never observed muscle spasm to be the cause of difficulty in breathing. There were 3 patients with less respiratory embarrassment due to moderate thoracic involvement treated with hot packs to the chest. These have been described. We felt, and still feel, that patients with severe thoracic involvement belong in a respirator and that they should be put there as soon as definite weakness is manifest and before fatigue has cut down their reserve. However, in so far as possible we used the Kenny treatment to the extremities on patients when they were in the respirators. Out of 96 patients, 90 received the Kenny treatment.

Our figures on degree of recovery from an orthopedic viewpoint cannot include every one seen originally, because some patients have not returned for follow-up. Of the 70 paralytic patients, 8 expired and 10 were not followed.

On a qualitative scale the degree of recovery to date (June 1, 1945) of the 52 paralytic patients who have been under observation is shown in table 7. This is a tentative report, since many more months, and in some instances years, will

be necessary for final calculation of degree of recovery. Of the 26 non-paralytic patients there are 4 who still have some unilateral spasm of their back muscles. In these 4 patients we shall be interested to see whether or not a scoliosis develops; at present they have no deformity. Since they are under treatment we do not anticipate such a sequel from this group. It is at this point that one wonders if some of the children seen with an idiopathic scoliosis might not have had undiagnosed acute poliomyelitis from other years.

TABLE 7
Degree of Recovery for 52 Paralytic Patients with Poliomyelitis

DEGREE OF RECOVERY	NO. PATIENTS
Complete.	14
Moderate.	27
Slight.	11
Total.	52

There were 8 deaths altogether. Seven of them have been discussed in connection with the patients having respiratory failure. The eighth occurred in a 35-year-old colored female. In addition to her poliomyelitis she had diabetes mellitus. Autopsy also revealed extensive renal pathology of long standing. Her death was

probably the result of a combination of these conditions.

The following schema (chart 5) summarizes the assembled "vital statistics" of the cases.

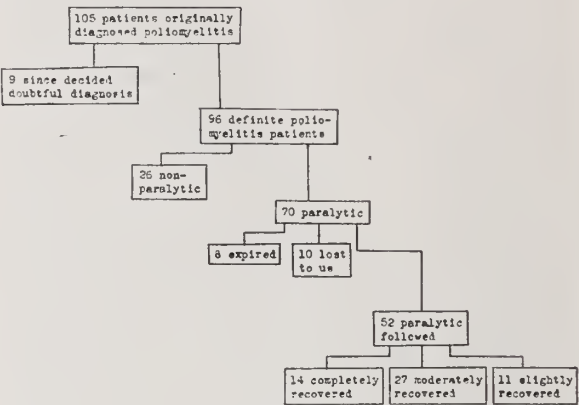


CHART 5

We wish to express our appreciation to Dr. Shirley Martin and Dr. Frieda Wilhelm for their assistance in tabulation of the statistics.

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HOW IS A DEPRESSION DIAGNOSED?

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THE present-day treatment of pathologic depressions is sufficiently well established so that physicians should be more aware than ever of the great importance of recognizing this common condition. Through early recognition one can apply electric shock therapy in the indicated cases and prevent many suicides as well as reduce the duration of the indescribable misery suffered by the people afflicted with this disease. In addition, proper diagnosis may eliminate unnecessary diagnostic procedures and needless surgical operations.

In spite of the fact that depressions have been described for many years, the disease has been neglected by the physicians not specializing in psychiatry. It is probable that this deficiency in diagnostic acumen may be due to faulty teaching during the medical school period, and later. In the past the case of moderate to severe depression that had reached the stage requiring institutional care has been emphasized. As a result there has been neglect of the mild to moderate grade of depression which is so frequent in the general population. This group of patients is not sufficiently agitated to require institutional care but can often be treated in a general hospital or even in an ambulatory manner.

The purpose of this paper is to describe to general practitioners the outstanding manifestations of this second group of cases so that the condition may be properly diagnosed instead of being labeled "nervous breakdown, neurasthenia, just your nerves, chronic nervous exhaustion, nervous indigestion." In common with other conditions, an excellent principle concerned in recognizing depressions is to be aware of the possibility that they exist. Because of the above-mentioned deficiency in educating physicians

this condition is probably one of the most consistently missed in medical practice. Typical depressions are often characterized initially by physical symptoms. For that reason the physician may treat one of the symptoms and not recognize the true nature of the illness. The symptoms enumerated below are an attempt to present a clinical picture, with the manifestations listed as they ordinarily appear. As one elicits the history, he must keep in mind that the patient is describing or exhibiting a change in his usual self, a change in the way he formerly went about his activities, and the manner in which things appealed to him. Patients who all their lives were happy, congenial, cheerful, interested in many activities, looked on the bright side of things, enjoyed people, etc., now find themselves acting and feeling just the opposite. The physician must not make the error of believing that a cause must be discovered before a diagnosis of depression can be made. A large percentage of depressions exhibit no known or overt cause but are apparently spontaneous in onset—and in recovery. It is believed that about 50 per cent of patients give a history of previous attacks from which they recovered spontaneously after a duration of many months.

The symptom which most commonly heralds a pathologic depression is insomnia. The patient usually says that formerly he slept well but that he began awakening very early in the morning and finding it impossible to return to sleep. Very soon he finds difficulty in falling asleep. Then, during these two wakeful periods the patient begins to be disturbed over the feelings associated with his depression and as a result finds himself unable to sleep at all. In deep depressions patients are so beset by depressive

thoughts during the night that they become quite agitated and spend the night literally pacing the floor. The complaint of persistent insomnia should immediately suggest the possibility of a depression and lead one to question the patient accordingly.

The next outstanding symptom is loss of appetite, sometimes associated with some vague gastrointestinal symptom, commonly constipation. In this regard one must not be misled by the patient's statement that he eats as much food as usual. Simple questioning may quickly reveal that the patient is eating his usual quantity of food, but not with the gusto, zest and interest he formerly had for food. This last is really what constitutes appetite. In the average depression the patient states, "Oh, I can eat, but it has no meaning for me; the food is tasteless; it all tastes alike."

Depressed patients consistently exhibit degrees of changes in their former interests. This varies from a diminution to a complete loss. They consistently reach a point where their former interests, whatever they may have been, no longer have any appeal for them. This applies to work, feelings toward family, radio, reading, movies, recreations, etc. Instead of engaging in their former activities, they "sit around and mope, or brood," as they describe it themselves. This change in former interests commonly affects the sex drive, which may be absent.

As the name of the disease implies, the victims become depressed in spirits or mood. This symptom must be present before one can make the diagnosis, and occasionally it may be difficult to elicit. One must keep in mind some synonyms for depression, and his difficulties may be decreased. Patients refer to feeling "melancholic, dejected, blue, morose, in the dumps, moody, down in the mouth, downhearted, not happy, sad," etc. Patients may state that they feel "wretched, miserable, unhappy, horrid, useless." All of these phrases are possible clues to eliciting a history of depression in spirits. An important feature of the depression in spirits is

the curious phenomenon of "diurnal variation." By this is meant that the patient feels most depressed in the morning, usually immediately on awakening. As the day progresses his spirits and general outlook may improve to such a degree that after 3 or 4 p.m. he may feel quite normal and by 6 to 8 p.m. he may be quite cheerful. Patients readily explain this apparent discrepancy by stating that when they first awaken they feel so utterly miserable and time passes so slowly that they cannot visualize themselves living through the day as it stretches endlessly before them. As the hours pass they feel better because there is less of the day remaining.

As a result of the foregoing symptoms, and others, the victims of this disease are susceptible to suicide. They feel so miserable, unhappy, useless, "in the way," depressed, unable to carry on their usual pursuits, that it is a wonder that the suicide rate is not greater. It is important, but not absolutely essential, to obtain a history of suicidal thoughts. However, it is unforgivable ever to ask a patient directly if he has thoughts of suicide, because an injudicious question may give him thoughts he did not possess. Try to obtain information about suicide by indirect inquiry, "How deep is your depression?" or "How low do your spirits get?" The frequent reply is "as low as they can get" or "so low that life doesn't seem worth while." Such replies are equivalent to expressions of suicide.

Universally there are changes in the manner in which the future appeals to them. They state, "The future seems very dark, hopeless, gloomy, black; I can't see any future; I don't see any hope of getting well." This is one of the most important characteristics of this condition.

One of the most common physical complaints is that of fatigue. Many patients are almost completely disabled as a result. However, close questioning will often reveal that it is really apathy which is disturbing the patient, the apathy so closely associated with diminution or loss of interests. On hasty examination one too

often diagnoses "neurasthenia" and makes no attempt to obtain the remainder of the history and make a correct diagnosis. Very often one discovers that the fatigue results from the intractable insomnia. When the patient is able to sleep the fatigue may be alleviated.

So many depressed patients state, "All I do is think of myself; I can't get my mind off myself; I wish I could think of other things as I used to do," etc. As a result of this introspection, the patients complain of poor memory and inability to concentrate, and then as a result of this they are certain they are going crazy or losing their minds, an almost universal fear and a most disturbing one. Many times there is indecisiveness, in varying degrees, and affecting even the most trivial matters. Patients may state that they are unable to think as clearly as formerly, that their minds seem "foggy, clouded, things seem 'out of focus,' mental processes are slowed down."

Crying, an overwhelming feeling of misery, and a frightening fear of some evil foreboding accompany the feeling of depression of mood. Some of the patients may cry continuously, others but rarely. The feeling of misery is common. When describing the feeling of foreboding, the patients characteristically put their hands to the precordial region or to the epigastrium and state, "I have such a heavy feeling in here" or "I feel like something terrible is going to happen, but I have no idea what it might be."

A most important consideration is the patient's facial expression. So many patients actually look depressed; they don't smile, nothing seems funny to them, they look miserable and unhappy. In addition, there may be evidence of neglect of personal appearance.

During the period of depression, many patients, more especially the older ones, will complain of feeling so useless, feel that they are in everyone's way and that everyone is too good to them. They often have overwhelming feelings of guilt but don't know of what they feel guilty. Under these conditions the patient may become agitated, pace the floor, wring his hands, cry, etc.

The possibility of a depression must be kept in mind when the patient has *previously* enjoyed good health and then after the age of 30 or 35 begins to complain of what may seem to be "neurotic" symptoms. This is especially significant if the complaint is referable to a fear of heart disease or takes some other monosymptomatic form. It is unlikely that a person will have good mental health for 30 or more years and then suddenly become neurotic. When this person presents himself one must examine him thoroughly in order to rule out depression as well as organic diseases.

The patient may attempt to "cover up" his symptoms or to make light of them. For that reason it is essential that the physician question members of the family or other persons who may have observed the changes in the patient's actions.

To one who is interested in the problems of depressions it is most distressing to read daily in the newspapers of the suicides. Many of these occur in people between the ages of 30 and 50. In connection with these cases it is worthy of comment that too often the news item states the person had been "in ill health, was despondent, was depressed, was melancholic," etc. It is probable that most of them had depressions and that many of them were not recognized as such. It is a remarkable phenomenon of medical practice that physicians will make extensive examinations in order to avoid the stigma of missing an organic disease but do not feel stigmatized when they completely miss a diagnosis such as a depression, and especially after the patient has committed suicide.

Diagnosing and treating a depression is one of the most gratifying experiences in medical practice. People suffering from depressions are almost universally solid and stable citizens who are most grateful for their physician's help in bringing them to recovery. Upon recovery these people return to their usual, normal behavior and are able to carry on as if they had never been ill.

President's Page

WE BEGIN ANOTHER YEAR

I wish here to express my gratitude to the men who with fine coöperation accepted the chairmanship of the different committees, and to all the members of those committees. It will take time and energy when they have not much to spare in these busy war times. Many have served before through other administrations, and although they have given generously of themselves, I am sure there was a return in satisfaction that comes with unselfish service.

There is something about getting to know more about the Society and its problems. There is something about groups working together that develops enthusiasm, and enthusiasm means "God In Us." It seems to me the Medical Society is growing to mean more and more to us as the years pass. It is not only a forum for the discussion of medical problems, but there is the opportunity to enjoy the fellowship of our fellow members, and to have the inspiration of meeting some of the leaders in medicine who come here to make addresses before the Society.

I have been very much impressed since I have been around our building more to see how many of our Society avail themselves of the opportunity of seeing our able Secretary, Theodore Wiprud, and discussing their problems with him. He seems to know every member, and his advice always impresses me as being wise and friendly. I think his letters to the men in the service have been splendid, for they remind our service physicians that we have them in mind and that they will be welcomed home after the war is over.

Finally, medicine like religion should not be static but should grow. There is a changing order all about us, and just what will evolve, just how the practice of medicine will fit into the new order, I can't visualize at this writing. But if we all give it our best thought and effort, and if we all work together with the ideal of service, I think our Medical Society, and we the members of a wonderful profession, will all go to a higher level of endeavor.

Wm. Earl Clark



WILLIAM EARL CLARK, M.D., F.A.C.P.
President, The Medical Society of the District of Columbia, 1945-1946

Editorials

WILLIAM EARL CLARK, M.D., F.A.C.P.

Dr. William Earl Clark, 79th President of the Medical Society of the District of Columbia, is one of Washington's best known physicians. His outstanding abilities have won wide recognition. This is not surprising when one learns that his grandfather and several uncles were also physicians. For where families are well represented in the profession there is talent and love for medicine.

Dr. Clark was born in Philadelphia on September 16, 1879. Most of his early life was spent in the suburbs of that city where he attended the public schools. When his family moved to Washington in 1897, he enrolled in the Corcoran Scientific School at Columbian University. At the conclusion of one year's study he entered the George Washington University School of Medicine, at that time Columbian Medical School, from which he was graduated in 1904. He interned at Garfield Hospital, Washington, and then at the old Pennsylvania Hospital in Philadelphia. Upon his return to Washington he became associated with Dr. William Gerry Morgan, an association which continued for ten years.

Upon the outbreak of World War I, he volunteered for service with the American Red Cross. He was first attached to the American Ambulance Hospital, following which he was assigned to two different evacuation hospitals in France and finally to the Army of Occupation in Germany.

Returning to the United States in 1919, he entered the practice of internal medicine, devoting himself largely to gastroenterology.

Dr. Clark is Clinical Professor of Medicine at Georgetown University School of Medicine,

Washington. In 1943 he served as President of the George Washington University Medical Society. He is a member of several scientific organizations, among them the American Medical Association, the American College of Physicians, the Southern Medical Association, the American Gastro-Enterological Association, the Pan-American Medical Association, the International Medical Association, the Clinico-Pathological Society and the Hippocrates Galen Society, the latter two of Washington.

In 1907 Dr. Clark married Miss Mary Harper, who died several years ago. He has two daughters, Martha, who is with the U. S. Marine Corps, and Judith, who lives at home. Dr. Clark was married again in 1941 to Miss Ivy E. Hamilton. The Clarks make their home at 5220 Partridge Lane.

It has often been said that hobbies reveal the man. If this is true, Dr. Clark is a man with zest for living, for his avocations are varied. He has a summer home at Mt. Desert Island, Maine, where he indulges in yachting. Significantly, he is Vice Commodore of the Northeast Harbor Fleet. He also enjoys golf, although it is said that he does not take his game too seriously. Photography is another of his hobbies, and he indulges in it with great enthusiasm.

What all this adds up to is that the Society has as its leader in the coming year a man of the highest professional standing, whose attractive personality and enthusiasm qualify him for the responsibilities of high office. The Medical Society's membership can therefore look forward to the coming year with the assurance that it will be a very successful one.

RETURNING MEDICAL OFFICERS WISH TO SPECIALIZE

The Committee on Postwar Medical Service* has just completed an analysis of 21,029 questionnaires¹ returned to it during the past year by medical officers on duty with the Army, Navy, Public Health Service and Veterans Administration. On the basis of this return, which represents more than 35 per cent of all medical officers on duty, the Committee has ascertained the educational desires of returning physicians in the way of refresher and postgraduate courses and will recommend how they can best be met by the educational facilities available.

Nearly 60 per cent of the total number who returned questionnaires wanted postgraduate education in the form of long courses (more than 6 months' training); more than 20 per cent wanted short courses (6 months or less), and less than 20 per cent wanted no further training. To offset the disadvantages of a wartime accelerated training program, an overwhelming majority of the young graduates of 1941-1943 desired more than 6 months' training, a particularly encouraging aspect. This proportion held almost equally true with the 1935-1940 graduates. Almost half of the largest group to return questionnaires (graduates of 1930-1934) desired more than six months and the remainder were divided between those wishing six months or less and no further training.

Of those preferring short courses in the specialties, the ten most popular were (figures in parentheses indicate percentage of each group who desired certification by a specialty board): internal medicine (54), surgery (65), obstetrics

and gynecology (58), pediatrics (40), otolaryngology (53), ophthalmology (42), psychiatry and neurology (68), radiology (44), orthopedic surgery (71), and urology (55). Thirteen per cent of those who specified short courses wanted a general review.

Long courses in the specialties were requested in the following order of frequency (figures in parentheses indicate the percentage in each group who wanted certification by the board): surgery (83), internal medicine (82), obstetrics and gynecology (82), psychiatry and neurology (84), pediatrics (81), orthopedic surgery (88), ophthalmology (85), radiology (84), otolaryngology (81), and urology (89). While the order of frequency varied slightly, the same ten fields were most popular for both short and long courses. Ten per cent of those who specified long courses desired a general review.

Nearly two thirds (63 per cent) of the entire group who returned questionnaires desired to become certified specialists. Nearly 16 per cent were already certified by the specialty boards, and the remaining 21 per cent either did not care to be certified or did not mention their desires.

The preponderance of requests for short courses in most of the specialized fields of training came from those who graduated between 1930 and 1934. There were exceptions. Anesthesiology counted its greatest number of requests from the graduates of 1935-1937, and the fields of hospital administration, pediatrics, plastic surgery, surgery and urology attracted in greatest number those who graduated between 1920 and 1929. It might be noted that in the fields of surgery and internal medicine requests were almost equal in number from the 1930-1934 and the 1920-1929 graduates.

In the matter of long courses there is greater variation with respect to age in the various fields of training. As might be expected the greatest number of requests in most fields came from the graduates of 1941-1943. These fields were anes-

* This Committee is composed of representatives of the American Medical Association, Association of American Medical Colleges, Advisory Board for Medical Specialists, American College of Physicians, American College of Surgeons, American Dental Association, American Hospital Association, Catholic Hospital Association, Federation of State Medical Boards, Procurement and Assignment Service, War-Time Graduate Medical Meetings.

¹ Lueth, H. C.: Postgraduate wishes of medical officers; final report on 21,029 questionnaires. *J. A. M. A.*, 1945, 127, 759.

thesiology, internal medicine, neurologic surgery, obstetrics and gynecology, pediatrics and surgery. The fields of otolaryngology, orthopedic surgery, pathology, psychiatry and neurology, radiology and urology appealed in greatest numbers to those in the 1938-1940 group. Ophthalmology and plastic surgery had the widest appeal to the 1935-1937 graduates; of those who chose dermatology and syphilology, industrial and insurance, proctology and public health, the most frequent requests were from the 1930-1934 group, and of those who wished to specialize in hospital administration, the 1920-1929 graduates predominated.

More than 80 per cent of medical officers specified the type of practice they were engaged in previous to military duty. The distribution was approximately as follows: private practice 51 per cent; internship 27 per cent; residency 13 per cent; other hospital status 4 per cent; regular corps officers 1 per cent; other type of practice 5 per cent.

In each group the proportion desiring specialty board certificates was as follows: private practice 63 per cent; internship 80 per cent; residency 90 per cent; other groups 75 per cent.

It appears from these figures that the trend is still toward rather than away from specialization. Two thirds of this large group wanted to become

certified specialists in addition to the 16 per cent already certified.

Will the metropolitan centers be able to absorb most of these specialists or will numbers of them seek location in smaller cities and rural areas? If decentralization occurs, will this latter group be able to afford the facilities for specialized practice, and, if not, to whom will they look for financial assistance? Is the need for the general practitioner waning or is there an opportunity for service in this broad field of which the young physician is now not fully cognizant? Is there greater emphasis in our medical schools today on specialization or has the desire for certification by specialty boards been given impetus by medical practices employed in the armed services?

These are some of the questions which must have occurred to members of the Committee on Postwar Medical Service. Will the Committee seek to divert a sizable proportion of these returning physicians into general practice or will it encourage the present trend toward specialization? Its recommendations for postwar education will be awaited with interest. How these medical resources can best be utilized in actual practice to the best interests of both the patient and the physician might well be included in the Committee's recommendations.

A. L. E.

THE STATUS OF ELECTRIC SHOCK THERAPY

Electric shock as a therapeutic device has become so well established that information concerning its benefits should be more widely disseminated. Too often knowledge pertaining to treatment of mental diseases is confined to those physicians especially interested in this subject. With this form of treatment we have a device which is being used with remarkable results in general hospitals and even in the offices of doctors.

Primarily, electric shock is indicated in depressions, of all types. It is reported to have some

value in schizophrenia, especially the catatonic type, and to be of no value in the psychoneuroses (with rare exceptions). Some success has been reported with patients in manic states.

With trained personnel and careful technic the complications may be reduced to an almost negligible number. The patient eats no breakfast the morning of the treatment. Hairpins and removable teeth are removed. During the active convulsive phase of the treatment the patient's back is placed in hyperextension, his shoulders are held against the bed, and all his

extremities are kept in adduction. This technic prevents dislocations and fractures. Skill, as much as strength, is required for this purpose, and nurses or nurses' aides may be used most satisfactorily. In the case of large, strong patients one may give a preliminary injection of curare intravenously for the purpose of weakening the muscular contractions.

The average depressed patient requires 8 to 12 treatments, which are usually given on alternate days. In the case of severely agitated patients the treatments may be given daily. Because of the ease of administration the treatment is widely used as an ambulatory procedure. The patient is brought to the hospital or doctor's office, receives the treatment, sleeps and rests for 30 to 60 minutes, and then is escorted back home. He remains at home between treatments. By this means one can treat a large number of patients who would otherwise require care in either a general or a mental hospital.

The outstanding feature of the treatment is the complete amnesia for everything associated with it. This is obviously a great advantage because the patient has no apprehensions and therefore no objections to subsequent treatments.

A great many patients with depressions recover spontaneously and completely. The great advantage of electric shock is that it terminates an attack within a month or so; otherwise the patient suffers a miserable existence for many months or even commits suicide. The prognosis with this treatment is excellent, and some recoveries are most dramatic. A duration of symptoms of many months or several years does not necessarily portend a poor prognosis. The recovery rate varies from 75 to 87 per cent, as reported by various workers. Most reports reveal that the recovery rate in involutional depressions is about 5 per cent higher than in the manic-depressive group.

I. R.

NEW BILL IS BEST SELLER

The latest edition of the Wagner-Murray-Dingell Bill is a volume more than twice the size of its immediate predecessor and classified by the Government Printing Bureau as the leader among its best sellers.

In introducing the bill Senator Wagner made several statements about which there will be divergent views. For instance, he says that the measure does not provide for taxation; the wage deductions (8 per cent) are to be considered contributions, but he admits more funds will be necessary and these are to be contributed by the Government from general funds raised by taxation.

Senator Wagner denies that the administration of the medical program is socialistic, although the employed individual must "foot the bill" whether he accepts the service or not. Choice of physician is also limited to those who elect to work under the plan, and they must accept Federal Government supervision of their services.

The over-all program will be under the direction of the Surgeon General, but local employees of the Government who may be vaguely qualified will pass upon the scientific needs of the eligible beneficiary. And it is implied all through the bill that the beneficiaries are to receive greater benefits than they could provide for themselves and at less cost than they are actually worth. In this they are to trust the Government as they would a wise and indulgent parent.

Included in the bill is a provision for a ten-year program of hospital and health center construction similar to what is planned on a one-year basis in the Hill-Burton Hospital Bill. This latter bill is commanding wide approval. Sponsors have included provisions for dental and nursing care that were omitted from the earlier bill. The employed when idle because of illness are to be compensated as well as if the unemployment were due to any other cause.

Provision is made for subsidizing research in the medical and public health field. The value of carefully conducted scientific research is generally acknowledged, hence adequate funds should be made available for its effective continuance and development. These features of the bill have real merit as do those applying to social security, and if taken separately might with some modifications well be enacted into law. But the sickness insurance section is far from desirable.

Attempts were obviously made to remove some of the most objectionable features of the earlier bill. The Surgeon General is to have the advice of a committee nominated by organizations having an interest in health. In addition the committee will have power to demand a conference with the Surgeon General. The administration generally is to be on the state level but there will still be the same machinery for inspection and control and the same need for voluminous paper work which depresses all Government assistance.

Health and Accident Underwriters' latest report shows that more than 40,000,000 persons

are covered by some form of health and accident insurance and it is variously estimated that upwards of 20,000,000 have hospital insurance and more than 4,000,000 have some form of sickness coverage. These figures are growing rapidly as the people discover the availability of such coverages. They have more than doubled in the last five years. Since these groups are organized on a voluntary basis and require no extra taxation it would seem wise to postpone any compulsory measure until the need for Federal interference has been proven.

At all events it would seem to be the American and democratic way to encourage the voluntary projects in which the individual subscriber has an immediate interest. Compulsory assessment or deduction does not guarantee that the insured can employ the medical services that may be available, and little comfort can be taken in the observation "it's theirs if they want it." This is a matter of grave importance. Physicians should not only discuss each feature of the bill among themselves, but they should talk it over with their patients individually and in groups.

X.

In and Out of Focus

BY THE OBSERVER

Famed Scientist Visits Washington

Your Observer recently attended his first news conference as a reporter. The occasion was an interview granted by Sir Alexander Fleming to Washington newspapermen. The British Information Services had informed the Society that a representative of the MEDICAL ANNALS would be welcomed.

Upon his arrival at the Services' offices, your Observer found himself one of approximately 100 reporters and photographers. Promptly at the

appointed hour Dr. Fleming arrived with a group of public relations advisers. One tall, suave Britisher introduced Dr. Fleming to the group. The eminent scientist proved to be a shy, somewhat embarrassed man of medium height with gray hair and pale blue eyes. However, he responded good-naturedly to all questions although obviously on the alert for those which might prove embarrassing. Reporters seemed as ill at ease as he was, the reason probably being that they hesitated to make themselves appear ridiculous by asking questions which might seem

scientifically inane. Nevertheless, the conference proceeded with some interesting results.

Dr. Fleming said he was in this country to visit the various medical institutions where experiments were going on with new methods of administering penicillin. He had kind words especially for our military hospitals, although he had not yet had an opportunity to see much of the work that was being done.

As to his discovery of penicillin, he said that its value had far exceeded any hopes he had in the beginning. Of the future he would not hazard a guess. Much will depend upon the success which attends the efforts to synthesize the drug. It will require "chopping it about" a good deal, he said. He reminded his questioners such experiments were out of his field for he was not a chemist but a physician.

Dr. Fleming expressed surprise that no one asked him about the value of penicillin in venereal diseases. Gonococcus infection, he said, was now much less cause for concern than a cold in the head. However, in the treatment of syphilis the results were not so definite. Considerably more experience will be required to determine the effectiveness of penicillin in this disease.

As stated previously, Dr. Fleming will visit a number of cities throughout the United States. It is hoped that the medical profession of Washington will be privileged to hear him speak. At the time this is written, indications are that this hope will be realized.

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*Searching
Self-Criticism
Advocated*

In reviewing some of the things he has written, your Observer is conscious of the critical tone of some of his comments. One of the things about which he has been particularly vocal is the lack of constructive medical leadership. Perhaps he could have expressed himself more moderately. Be that as it may, he is still of the opinion that where the provision of medical

care is concerned organized medicine on a national level has had little to offer in the way of a program. There are those who would challenge this statement. Nevertheless, your Observer stands by the position he has taken.

There are, of course, others also having the best interests of the medical profession at heart who hold somewhat similar views. For example, the *Pennsylvania Medical Journal* recently editorialized on the subject "Better Medical Care."

"In general," the Journal says, "we have been persistently guilty of obstructing any plan which might change certain methods of practice for the better and have adopted a negative attitude as evidenced by such recent publications as 'The Doctor Glares at State Medicine' or 'What You Can Do to Defeat State Medicine.' Worst of all are the undignified, unprofessional, petulant threats of active resistance adopted from trade union methods. It is a great misfortune that no real leader has emerged among physicians to lead us toward constructive *evolutionary* changes, and to have had the lead taken from us, only temporarily we hope, by laymen.

"If we ourselves, singly or collectively, had arranged for the better distribution of better medical care many years ago, there would be no furor now for the socialization of medicine. Schemes for the establishment of group services or diagnostic clinics were, as a matter of fact, planned for by the Philadelphia County Medical Society only to be interrupted by the war, but we should at least continue to plan along these lines.

"In the meantime let us attempt to correct some evils and shortcomings of our own. Let us indulge in some searching self-criticism rather than in mutual admiration and self-complacency. We boast of the good health of the United States, yet we read that 40 per cent of men of military age are physically or mentally unfit for military duty. There is a real need to change some of our methods and to abandon many traditional, habitual, outmoded, unnecessary expensive therapeutic procedures and operations, which in themselves contribute to the high cost of medical care.

"The growing realization of the importance of mental influences in disease should do away with much unnecessary medicinal and surgical therapy and stimulate the substitution of proper principles. According to recent reports, about two-thirds of illness encountered in general medical practice is essentially neuropsychiatric in origin and half of the patients in hospitals are there because of serious mental disorders."

What can the medical profession do in a constructive way? The *Journal* makes the following suggestions on this point:

"We should correct the custom here and there to charge exorbitant fees for medical services and surgical operations. It is noteworthy that the few whose fees, for no particular reason, are often far out of proportion to services rendered are frequently the ones most vehemently obstructive to any changes of practice which might interfere with their own little world.

"We might bring about some plan whereby a large group of physicians who never attend medical meetings could be kept 'up to date.' Perhaps we should all voluntarily, or otherwise, submit to reexamination at regular intervals for continual qualification for licensure, or at least be obliged or compelled regularly to attend postgraduate courses of instruction and receive certificates for permission to continue to practice.

"We ought to correct some of our inconsistencies. For example, we justly abhor 'political medicine,' yet we tolerate just that in many political appointments of our city and state directorships of public health, which are subject to rapid change with change of the party in power. Far more attention must be given to preventable disease than heretofore, and this can best be done by persons who are trained for the work and who have an uninterrupted tenure of office, with an adequate staff and facilities.

"It is to our best interests if we admit, at least among ourselves, the self-evident fact that times are changing and our methods of practice should change with them, without necessarily confusing change with progress. Whatever improvements are brought about will, perhaps, require some uncomfortable readjustments, particularly among older physicians. Those in military service who reënter civilian practice after the war will find it easy and desirable, since military medical practice is directed toward modern organization; and many are said to have already expressed their desire for group practice. Young graduates should have no difficulty at all."

The *Journal* concludes:

"Now, if at considerable effort and some pain we, as physicians, set a good example and succeed in bringing about a degree of improvement to justify our professional status, we have every reason to demand better coöperation by the public at large. There should, for example, be greater restriction of irregular practitioners, healers, and the like who do not have to spend twelve to fifteen years in preparation for their work as we do. There

should be greater restraint on misleading commercial medical advertising and on ill-advised medical articles in lay magazines. The public must be educated to accept modern public health measures, to accept medical advice from legitimate sources, and to realize that the modern management of disease often requires measures other than bottles of medicine, pills, injections, or operations. With a little coöperation and mutual readjustment, there is no reason why progress cannot be made without ill feeling, providing there is less argument and more work."

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What One Labor Leader Thinks

As is well known, labor organizations, particularly the C.I.O., are solidly supporting the Wagner-Murray-Dingell Bill. Not only that, but they are putting on a real fight for its passage. Hard-hitting, able spokesmen for labor are using all the persuasive power they possess.

Last October Clayton W. Fountain, representing the United Automobile Workers of the C.I.O., addressed group hospitalization executives at Cleveland. He "pulled no punches," as the following extracts from his speech reveal:

"Our union, the UAW-CIO, with a membership of well over a million workers in mass production industries, is on record in favor of enactment of the Murray-Wagner-Dingell Bill.

"Now we of labor know that most of you folks in the medical profession disagree with our stand on health legislation. Many of you think that we want to socialize medicine and place the distribution of medical care under a blanket of bureaucracy and regimentation. . . .

"First of all, labor does not want the state to step in and take over direction of all social functions. This is as true of medicine as it is in any other phase of our society. We only ask for the assumption or responsibility by the state in those areas of social action where private agencies fail to do a proper and adequate job of satisfying the needs of the people. . . .

"So now I say that labor supports the Murray-Wagner-Dingell Bill because private agencies in the medical field are not doing a proper and adequate job of insuring the health of the common people of America. It is strictly a practical problem with us. I hope I can make that point clear. You will not change our minds on this issue by talking in terms of socialized medicine,

bureaucracy, regimentation and all the other semantic nonsense with which this controversy has been cluttered up. What we are interested in is whether or not Joe Worker has the cash to keep himself and his family healthy—on a pay-as-you-treat basis, by prepayment, or by a system of government health insurance.

"Joe Worker wants health, and he is going to get it, one way or another; and you cannot turn him aside from his quest for health by stuffing him with arguments against bureaucracy and regimentation. Health to him is like unemployment compensation. He knows that modern medical science can provide him with health. So if those whose business it is to keep him healthy do not do the job to his satisfaction, he is going to turn to the state for help. Where else can he go under a democracy? Didn't the founding fathers shape our government so as to enable the underdog to use it to help himself? . . .

"If, therefore, you medical people do not want Federal health insurance because you think it will subject you to bureaucracy and regimentation, you ought to take the practical approach of so organizing your affairs, that, even if such a bill is passed, it will have little, or nothing, to do. This is still a free country, you know. You organize the distribution of hospital care and medical care in a community so that every person in that community is guaranteed all the health he can get under modern standards of scientific achievement—and you do this through the endeavors of private agencies, and offer it to Joe Worker at a lower price than the government would charge him for the same services—and what do you think Joe Worker will do? Will he choose the higher priced government service? Of course not. And if you do that kind of a job in America, you will have met the arguments for Federal health insurance. But, until medicine itself offers Joe Worker more health security at lower prices than the government can submit, we are going to stand pat on our support of the Murray-Wagner-Dingell Bill.

"Of course, there are those among you who will say that this is a blackjack policy. They will say that we ought to abandon the Murray-Wagner-Dingell Bill and devote our efforts in the health field to expansion and promotion of private non-profit medical plans. And I say that, if we were to accept this advice, it would take twice as long, and it would be doubly difficult, to build Blue Cross up to the size it ought properly to reach in the very near future. And the reason for this is that medicine itself is ridden with a kind of private bureaucracy so steeped in individualism as to obstruct the necessary changes leading toward utilization of collective techniques in the dispensation of medical care.

"There are among you those who accept Blue Cross

plans, and medical plans organized upon the same principles as Blue Cross, as the lesser of two evils. They are opposed first, to government health insurance; and they are opposed, second, to private non-profit health insurance. It is all communism or socialism, or bureaucracy, or something, to them. However, seeing the upsurge of social sentiment in favor of group methods of distributing hospital and medical care, these recalcitrants decide that Blue Cross will disturb their system the least. If there must be organization and expansion of group techniques in medicine, they think to themselves, we must control such organizations as are set up to move in this direction.

"So it is only by the pressure of social sentiment that the most backward elements in medicine are compelled to make minimum motions in the direction of group techniques. They do this grudgingly; and, as I said before, they accept Blue Cross and plans like it as the lesser of two evils. So we of labor, standing in need of the benefits of modern group medical techniques, have to support Federal health insurance because great sections of the people actually need Federal health insurance.

"If, through our espousal of Federal health insurance, we prod the most backward elements in medicine toward acceptance of plans like Blue Cross, the end result is more health for the community. Does anyone oppose that result? . . ."

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Hartford Was Prepared

One of the most shocking tragedies in recent times was the circus fire at Hartford, Connecticut, on July 6, 1944. "In less than fifteen minutes," Dr. Donald B. Wells of that city says, "125 human beings, more than half of them children under fourteen, were burned to death on the lot. One hundred and eighty-three others, of whom 150 were burned, were admitted to the various hospitals, where 43 subsequently died."

Addressing his colleagues of the New England Surgical Society of Boston last fall, Dr. Wells revealed that Hartford was not unprepared for this terrible disaster.

"Ninety years ago, on March 2, 1854," he says, "a boiler blew up in the Fales and Gray Car Manufactory in Hartford, killing 19 persons and injuring 23." Public opinion was at a high pitch following the tragedy. There were

charges and recriminations. However, responsible citizens discussed the need for preparing for a possible repetition of such a catastrophe. Two months thereafter, the Hartford Hospital was incorporated and, according to Dr. Wells, "From a modest beginning the hospital has grown during the last eighty-eight years to become the most heavily occupied community hospital in the United States." He says an addition to the hospital, completed in 1942, is "where a considerable number of casualties of any type can be assembled and definitive treatment instituted in the event of civilian disaster. An adequate drive and ambulance entrance open directly into a large foyer, where are stacked sawhorses and standard stretchers. Immediately adjoining the foyer is the Triage Room, 60 by 40 feet. Here twenty beds are kept constantly made up. At either end are lockers containing all necessary emergency apparatus. The room is equipped with utility hoppers; oxygen is piped directly into it; there is central suction; heavy-duty rubber-covered electric cables with multiple-plug receptacles placed at frequent intervals lie on the floor. Down the corridor from the foyer are two air-conditioned emergency operating rooms with complete pressure-sterilizing equipment, ordinarily used as cystoscopic rooms. Here, and in the regular accident rooms, on the afternoon of the circus disaster, the casualties were admitted and received their initial morphine and plasma, laboratory determinations were made, wounds were dressed, and ultimately the patients were transferred to the wards as these were set up to receive them."

Like many other communities Hartford recognized the importance of blood plasma in case of disaster and had planned accordingly. When the circus fire occurred, the blood-plasma bank "paid a large dividend to the community that had had the forethought to set it up: nearly 28 gallons of plasma was injected into the veins of the victims—with only a single mild reaction. Furthermore, up to August 29, volunteers had

given an additional 85 pints of whole blood to the victims at the Hartford Hospital. It is interesting to note that a large part of the plasma, blood and electrolyte given the burned patients in the hospital was introduced directly into the femoral veins. Three hundred and thirty-five recorded femoral punctures were done by the house staff during the first three weeks following the fire without an untoward incident—nor were any common femoral veins ligated. One patient, who had sixteen femoral punctures, developed a transient, benign thrombosis of the right deep epigastric vein. In no case was any vein cut down on."

Speaking of the personnel which rendered such outstanding service following the circus fire, Dr. Wells reports: "Five hundred and eighty-five Red Cross nurses' aides had been trained and graduated since the first class was inaugurated in March, 1942. An organized group of volunteer business and professional men known as 'medical aides' had been formed at the Hartford Hospital in July, 1942, to meet the crises that had developed because of the disappearance of paid orderlies into the military services and expanded war industries. . . . A few of these volunteers were on duty at the Hartford Hospital on the afternoon of July 6. But as the news spread, a trained community flocked to the Hartford Hospital."

"Burns," Dr. Wells says, "are a special assignment at the Hartford Hospital, and a majority of all burns routinely admitted come under the care of the Burn Committee." "Within three minutes of the arrival of the first patient on the day of the disaster," he asserts, "the director, in accordance with plans adopted by the staff and executive committee more than two years previously, declared an 'emergency,' which automatically placed all the disaster burns on an equal economic level and under the sole professional care of the Burn Committee. As a result, every burn that came into the hospital on July 6 was uniformly treated. The committee's typed-out plan closely follows the so-called 'unorthodox method' employed at the Massachusetts General Hospital at the time of the Cocoanut Grove Disaster: immediate intravenous morphine; intranasal oxygen, if necessary; clinical evaluation of impending shock and

absolute priority treatment of existing shock with plasma in adequate quantity as determined by frequently repeated laboratory checks; no cleansing or débridement of the local injury; simple protective pressure dressings, using previously prepared sterilized vaseline strips overlaid with dry gauze carefully and smoothly applied; sheet wadding rather than mechanic's waste; and Ace bandages."

The results in burned cases it was pointed out were most satisfactory. "The circus fire as observed at the Hartford Hospital demonstrates," Dr. Wells concludes, "that possible civilian disaster requires thoughtful preparation and specific organization on the part of the community, a hospital with adequate physical equipment and trained personnel and, most important of all, an organized professional staff with a clear concept of peripheral vascular failure and the significance of laboratory data, of infection and the limitations of bacteriostatic agents, of nutrition, of the underlying principles of wound healing and of realistic psychiatry."



*Daniel
Webster's
Affliction*

Several years ago Dr. Creighton Barker, Executive Secretary of the Connecticut State Medical Society, gave an address on the subject, "Daniel Webster and the Hay Fever," subsequently published in the *Yale Journal of Biology and Medicine*. It has just been reprinted in the June issue of the *Connecticut State Medical Journal*. Dr. Barker was sufficiently interested in his subject to make an independent investigation, for he says "none of his biographers has thoroughly considered [Webster's affliction], no doubt because from their point of view it was of too trivial a nature in comparison to the sequence of high events that filled his years." Dr. Barker believed otherwise, and therefore his decision to investigate.

In what way did his affliction influence Webster's life and the course of the nation which he so faithfully served? That question will never be satisfactorily answered. But a revealing record written by Webster himself is helpful.

Webster first suffered from hay fever in 1832 when he was 50 years of age, which, according to Dr. Barker, "is an unusually late period in life for the symptoms to appear; in fact, it is at about that age that the severity of the disease often begins to wane." Annually thereafter in August he looked for the symptoms to appear. He says, for example, in a letter dated August 15: "In seven days I shall begin to sneeze and blow my nose, and the first week the catarrh is usually most severe." Much more along this line from Mr. Webster's correspondence appears in Dr. Barker's article.

As to treatment, Dr. Jackson of Philadelphia prescribed for Mr. Webster. "He adds iodate of iron to the hydriodate of potash." This and other medicines apparently did not agree very well with the eminent statesman's stomach, for he reports that his gastrointestinal tract became upset. He says: "My system is so full of iron, potash and arsenic, that my stomach has become deranged." However, he often drank "large amounts of whiskey, which has a somewhat contradictory effect upon hay-fever, increasing the severity of the symptoms by the stimulation of the peripheral circulation, but up to a certain point making those symptoms more bearable because of the exhilarating and anesthetic effects of alcohol."

"If one could stay at just the proper degree of inebriety during the hay-fever season," Dr. Barker observes, "and did not have anything else to do, probably the disease would not be very troublesome, and there is some evidence which leads one to the conclusion that this is what Mr. Webster tried to do, with frequent errors on the plus side."

Mr. Webster died in 1852 of a cirrhosis of the liver. There was also a hemorrhage from the stomach and bowels, and extensive dropsy of the abdomen.

In conclusion, Dr. Barker says:

"The interest of a medical historian in this subject is not limited solely to Mr. Webster's frank and whimsical

record of his annual vicissitudes with the hay-fever. There is indicated an intelligent inquiry into the possible effect and influence that the disease may have had upon his career. Any attempt at an appraisal of this effect must be based solely upon the facts as we have them, and be free from romantic conjecture. The facts are these: With the exception of 1839, when he was in the British Isles, Mr. Webster for twenty years suffered from an annual attack of what was undoubtedly ragweed pollinosis. The severity of these attacks increased as time went on, and it is very evident that he had an increasing apprehension of the disease each year. It is certain that he wished to withdraw from Mr. Fillmore's cabinet in 1850 because of the handicap under which he was placed by the disease. There is some evidence that his chance for the candidacy for the presidency in 1852 was hindered by a realization that he was not in good health. So many other factors, including his alliance with Clay, his bid for favor from the South by his advocacy of the Compromise, enter into the consideration that the issue is by no means clear. Moreover, all of the facts have not been examined. There is material bearing on this period at Harvard, at Dartmouth College, and in at least one private collection, that must be explored before a fair conclusion can be reached."



Telephone Etiquette

All of us are thoughtless on occasion. Sometimes we fall into habits that are irritating

to other people. Unless we recognize them ourselves, we may unintentionally alienate those with whom we associate. For example, your Observer talks to many people on the telephone daily. Of necessity he has resorted to time-saving devices, one being to have the operator in his office get the person he wishes to speak to on the line before he answers. He did not realize that this was at times offensive, if not in poor taste. He had to learn the hard way.

On an especially hectic day he had a call put through to a busy physician who was kept waiting a few seconds. Your Observer will not forget the going over he received. He was told that henceforth if he wished to talk to this physician to call him personally. That his time was as valuable as your Observer's. Further-

more, he said, it was only good manners. Needless to say, the same mistake was not made again. Now your Observer is on the line when the individual whom he calls answers.

He had not thought about this matter for a long time until he came across an editorial, "The Doctor's Telephone," which appeared in the *May Journal of the Indiana State Medical Association*. It is, in his opinion, well worth reprinting in this column.

"This is rather an odd subject for an editorial in a medical magazine," the *Journal* states, "but one which we have been threatening to comment on for many moons. The scene is that of a busy doctor's office—war-busy, if you please. He pauses to answer the telephone, and is told: 'This is Doctor "Big Shot's" office' calling; he wishes to speak to you; please hold the wire.' Well, we hold on like grim death until 'Big Shot' finishes an examination of a patient, or perhaps relates how he made a hole-in-one last week on a golf course. Finally, he deigns to talk, and says, 'Can you give me the name of a good pediatrician in Timbuktu? I have a family moving down there, and they want to consult a good man in that field.' Well, we look it up and give the best information at hand, answering several other inquiries as to the age of the specialist, his school and year of graduation, office hours, et cetera.

"Now, while we are glad to be able to be of service, all this takes time, and if the call had been made directly by the doctor himself much time could have been saved. The trouble is that the call-er does not realize that the call-ee is probably as busy as he is!

"A long time ago, when all doctors did not have secretaries, we could spot a new gal in a medical office right off, for no sooner had she been installed until the doctor would say, 'Get Dr.———on the wire.' The said Dr.———would have to stay on the telephone for a sufficient length of time to become impressed with the fact that he was being called by a busy man. Yet some of the busiest doctors we know can be reached directly by phone, without the caller having to give his name and state his business; this also applies to busy men outside the medical field.

"We once knew a doctor, a busy man, who answered no phone calls during office hours. We had occasion to call him several times, each time being advised that although he was in he could not be reached by phone at that particular time. Once his office hours were completed, this doctor took the phone calls in order and made each one of them himself. Quite some system, we thought.

"We would urge that a little more consideration be given the doctor to whom you wish to talk by phone; why not call him directly? As we have said, his time, too, probably is important. (We feel much better, having gotten this off our chest!)"



What Is Ethical Group Practice?

The medical profession has been charged many times with opposing group practice. Critics who make this charge lift an eyebrow when physicians protest that this accusation is untrue; that they have condemned only certain undesirable features of such practice. For example, physicians look unfavorably upon group practice when it is under the control of laymen. They have also opposed groups rendering service on a prepayment basis. However, they have always favored group practice when under the control and direction of physicians and where patients pay fees for services rendered. But critics are unmoved by such fine distinctions. Criticism of physicians on this score, therefore, still persists.

New York Medicine, in its May 5 issue, outlines steps which the Medical Society of New York proposes to take to meet this situation. The journal says:

"For many years organized medicine, as a whole, has been inaccurately portrayed as opposed to the principle of group practice of medicine. This impression has been widespread among the public. Such a misapprehension among our lay friends is doubly unfortunate because the principle of group practice, in so far as it is understood, usually appeals to the lay mind as being good common sense, and it has come to appeal to an increasingly large part of the profession as being conducive to good medicine.

"The fact is, of course, that organized medicine has never opposed group practice *per se*. It has forthrightly and with good justification disapproved of some examples of group practice which exhibited standards of ethics—and in some instances, of medical performance—which were unacceptable to the vast majority of the profession. Whenever the profession has disapproved certain group practices its action has been completely justifiable from the public standpoint and was, therefore, taken for the benefit and welfare of the

public. Regrettably, these aspects of the matter were not always sufficiently emphasized.

"In view of this background, we take satisfaction in recording the fact that on recommendation of the Coordinating Council of the Five County Medical Societies, and with the approval of the Comitia Minora, the Medical Society of the County of New York has given formal approval to the principle of group practice under ethical standards. A committee of the Coordinating Council is preparing standards for such groups, to be submitted to the Five County Societies for their endorsement.

"This action, as we have pointed out, does not constitute a reversal of medicine's previous stand in any respect. It is merely a public affirmation of a long-existing policy. It should serve to correct the record in a matter that is certain to receive increasing public attention in the years immediately ahead. Meanwhile we await with keen interest the standards for group practice to be prepared by the Coordinating Council."

This move by the Medical Society of the County of New York is a wise one. It is time that medical societies make their position clear where group practice is concerned.



Use Your M.D.

If your Observer's memory serves him right, he has previously had something to say about the title "doctor." Its use has become so commonplace that in many states where cultists flourish it means really very little. The informed, of course, think of doctors as physicians trained in medicine. However, there are many gullible individuals who accept anyone who calls himself "doctor" as being a qualified medical man. It has therefore been urged by your Observer and many others that doctors use the title "M.D." wherever possible. That will at least distinguish them from other would-be doctors who treat the sick.

The *Journal of the Tennessee State Medical Association* editorializes on this subject in its May issue. The *Journal* says:

"Let's see what a physician really is. According to the Standard Dictionary, he is 'one versed in or practicing the art of medicine, or healing bodily disease by the

administration of medicine. Specifically, one legally authorized to treat diseases; a doctor of medicine. . . often used figuratively in a moral sense.'

"The term doctor is practically synonymous, being defined as '(1) a practitioner of medicine or surgery, (2) a person who has received a diploma of the highest degree in a faculty as of divinity, law, etc.'

"If the terms doctor and physician were used according to the above definitions, we would be well on the way to curing much of the malady which is caused by 'many physicians.'

"Let us name some of the kinds of 'doctors' who are producing so much confusion.

"As doctors of medicine, we humbly assume our share of the cause of this suffering. We claim no infallibility. We believe we have a reputation for fair dealing and for giving conscientious service in our efforts to cure disease and relieve suffering by accepted methods.

"Doctors of dental surgery are likewise entitled to the same consideration we claim for medicine. Doctors of divinity, law, and philosophy certainly have their useful place in our civilization. They likewise may have at times, unintentionally, added to the suffering of humanity just as medical and dental men have.

"The above doctors are, according to the definitions, entitled to be called doctor. They have studied for years to earn the degree, and they spend their lives in sustaining the high standards of their professions.

"Be it far from us to say one word to detract from the service rendered by dispensers of drugs. These men are trained to carry out a very important function. They are closely regulated by law. They stand high in the commercial world. Admitting all of this, the custom of addressing them as 'doctor' is a cause of confusion, an unwarranted use of a title, and distinction not wanted by them. Even their soda jerkers are called 'doctor' by some of the ignorant who would not dare to use that title when addressing the attendants of fountains in restaurants.

"The most dangerous part of this doctor question is evident when our civilized world fills with cultists and quacks who masquerade under the title of 'doctor.' The writer once saw in China a Jap's sign reading, 'Dr. Isimato, dentist and fix eye.' In California it is much easier to find a cultist, legalized we hope, who guarantees his cures, than it is to find a legally qualified doctor of medicine. But why go away from home to look for such dangers? Not a week passes that does not bring word of the depredations of 'doctors,' practicing legally and illegally, who add to the suffering of our people.

"In the face of all this confusion, one suggestion may be beneficial. Let all of us who have received the de-

gree of doctor of medicine abandon the greatly abused and overworked title of doctor. On our stationery, prescription blanks, and doors let us have our names followed by the letters M.D. Let us consider the advisability of taking legal steps to compel all persons using the title doctor to indicate definitely whether they are doctors of medicine, dentistry, veterinary surgery, philosophy, law, divinity, osteopathy, chiropractic, naturopathy.

"Check your prescription blanks, stationery, and signs. Help kill this infernal use of the word 'doctor.' Even the daily press might then be more careful in conferring the degree of doctor on technicians, bacteriologists, druggists, and others who neither deserve nor want the distinction."

Amen!



**Overworked
Officials
Need
Psychiatric
Help** There is little praise these days for the most worthy Government bureaucrat. In fact, he is very much on the receiving end of none too gentle criticism.

As for sympathy, there is none for him.

In justice it should be said that there are many conscientious public officials in Washington who are working under terrific pressure. Although they have been cautioned by their physicians not to continue the fast pace which they have set for themselves, they insist upon doing so. It is not surprising then that emotional disturbances are a frequent cause of ill health in this group.

When Judge Jerome Frank, of the United States Circuit Court of Appeals, addressed the third annual Conference of Scientific Spirit and Democratic Faith in New York last month, he took cognizance of this situation, emphasizing the part psychiatry could play in maintaining the emotional equilibrium of our public officials. The first reaction to this suggestion, of course, is one of amusement. Small wonder the bureaucrats get jittery. They make everybody else that way. Yes, they are getting a dose of their own medicine. But Judge Frank was not in a humorous mood when he talked on this subject.

"Why, I ask, and not jocularly, should not those holding major administrative posts in government be required periodically to consult government psychiatrists?" Judge Frank said.

"My experience in government leads me to believe that a very considerable part of the friction between government departments, if one peered behind the rationalizations, could be traced to personality difficulties of one or more of the disputants."

Under the pressure placed upon them, he said, "the best of men at times become the creatures of inner drives and obsessions of which they have no awareness. An occasional chat by an overworked official with a government psychiatrist would make government run more smoothly. I do not suggest that psychiatry is, or can be, an exact science. At best, it is but an art, still in its infancy or adolescence. Yet, it has already proved immensely valuable, and it will be so increasingly, unless we allow it to become unscientifically authoritarian."



"The People Want Medical Security . . ." Last month your Observer commented on the enthusiasm and the progressiveness of the medical profession of Michigan. They had not only been energetic, he said, but had outstanding accomplishments to their credit. The fact is, of course, that the situation in Michigan demands that the profession be alert and forward-looking. For in that state as in California there are many proponents of wild-eyed social schemes. Labor, too, wields a great power in the state, and its influence on society in that commonwealth may well prove far-reaching.

Early in April a compulsory health insurance bill was introduced in the Michigan legislature "allegedly" sponsored by the C.I.O. The bill proposed was identical with that introduced in the California legislature early in the year. Its fate was the same as in California; it never came out of committee.

The *Journal of the Michigan State Medical Society* described this legislation as follows:

"The bill called for all employers and employees to contribute one and a half per cent each of an employee's salary to a state health insurance fund. This payroll tax would apply to salaries up to \$5,000 a year. The measure would create a seven-member health insurance commission with only one practitioner of medicine thereon! The others would be two members representing labor, two representing employers, one research man from a medical school, and one from the general public.

"The state agency would have authority to cooperate with the government in any federal extension of health insurance.

"Under the bill, no fee for service would be allowed; a practitioner would be paid by the state through straight salary or upon a capitation basis. No agriculturalist or self-employed person would be a recipient of services under the bill until certain 'studies' of their proposed inclusion under the plan had been completed. The medical cure and hospitalization of indigents are not mentioned in the bill.

"The executive director at \$15,000 a year can not be a doctor of medicine; the medical director at \$12,000 a year must be one selected because he favors the philosophy of state medicine."

If this legislation had been seriously considered the Michigan medical profession might well have been deeply concerned. However, for the time being it is dead. But the *Journal* warns that the introduction of the bill is an indication of a trend.

"The people want medical security," the *Journal* editorializes, "and because most of them (75.4 per cent) have never heard of voluntary programs sponsored by the medical profession, they look to government to do the job.

"When given a choice between voluntary prepayment programs sponsored by the medical profession vs. a government-controlled program, more than twice as many people vote for the former, as shown by the Michigan Survey sponsored by the Michigan Health Council (1944). The people have faith in the medical profession and prefer to cooperate in a voluntary program operated by doctors. That program must be broadened and universally accepted in the next two years, to insure a continuance of quality medical care to the people and the preservation of the time-tried methods of private practice which have made American medicine the greatest in the world. Let's do everything to keep it that way."

Washington Physicians of Yesterday



JOSEPH MEREDITH TONER, M.D.

Few Washington physicians have attained eminence in the medical world comparable to that of Dr. Joseph Meredith Toner. A man of great abilities, he was in his day known throughout the country. Born in Pittsburgh, Pennsylvania, April 30, 1825, he received degrees of Doctor of Medicine from Vermont Academy of Medical Science in 1850 and Jefferson Medical College in 1853. In 1867 he was given an M.A. degree by Georgetown University, the same institution granting him a Ph.D. degree in 1899. In the year 1874 he was President of the American Public Health Association, two years later being elected Vice President of the International Medical Congress, Philadelphia. New York and California State Medical Societies elected him to honorary membership, as did the Boston Gynecological Society. He was one of the founders of Providence Hospital and St. Anns Infant Asylum.

He was an authority on medical biography and local history of the District of Columbia, and published more than fifty papers and monographs upon subjects of interest to the medical profession. In 1882 he gave his entire library, including manuscripts, to the United States Government. It consisted of 28,000 books and 18,000 pamphlets.

Dr. Toner was the first President of the Columbia Historical Society. He died at Crescent Springs, Pa., July 30, 1896.

THE CONTROL OF RABIES IN THE METROPOLITAN AREA OF WASHINGTON

V. L. ELLICOTT, M.D., DR. P.H.

Health Officer, Montgomery County, Maryland

When rabies has been established in a community, the most effective procedure is a combination of three measures: (1) dog quarantine, (2) elimination of stray dogs, and (3) vaccination of dogs.

Montgomery County passed through a rabies epidemic which began in September 1943 and ended early in 1945. The reported cases totalled 144, of which 123 were dogs and 21 were other animals. No human cases occurred, but over 200 were treated because of exposure.

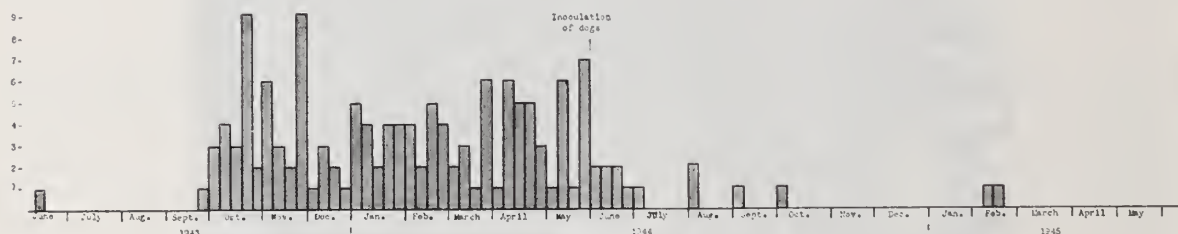
Infection was introduced into the County from the District of Columbia and from Prince Georges County in September 1943. It was true that 1 positive report (not shown on chart) had been received in the previous June, but this dog apparently infected no other animals. After September rabies

locations over a 2-week period beginning May 29. Places were well advertised. Each dog was given a single inoculation of 5 c.c. The State Livestock Sanitary Commission paid for the vaccine, and the County Commissioners paid for the veterinarians' services and other costs. The good response, estimated at nine tenths of the dog population, was due to the convenience of the plan and to the offer of exemption from quarantine of dogs wearing vaccination tags if subsequent rabies case reports justified. Three weeks later these vaccinated dogs were exempted. Quarantine, however, was not relaxed suddenly. Most dog owners wanted to continue to play safe.

From this time on the chart of reported cases tells the story.

REPORTED CASES OF RABIES IN ANIMALS

By Weeks, Montgomery County, June 1943 to June 1945



soon became firmly established in the eastern and western suburban portions of the County, new infections being reported at an average of 4 per week. The spread was rapid because of the stray and other unwanted dogs which had accumulated in the absence of a program for humane disposal. The disease continued at the same incidence through the winter and spring. Dog quarantines were maintained in the infected areas, and a dog-catching service was kept up.

In the spring of 1944, when cases began to occur in rural areas, farmers became alarmed about the safety of their livestock. The Farm Bureau therefore asked that dog vaccination be tried as an experiment. By this time 77 positive animals had been reported.

Vaccinations were free and were carried out at 30

In the adjoining County of Prince Georges the vaccinations were carried out between July 3 and July 14, 1944, when an estimated 75 per cent of the dogs were vaccinated. Since rabies was still prevailing in the District of Columbia this spring, both Maryland counties have repeated their dog vaccinations.

Montgomery County maintained an aggressive dog-catching service from October 1943 to November 1944. Approximately 4,000 stray and unwanted dogs were disposed of. Dog-catching was also carried out in Prince Georges County on a less extensive scale.

The following table of reported cases of rabies in animals is given to show a comparison with the Dis-

(Continued on page 335)

War Section

SERVICE NOTES

Lt. Colonel William H. Beard, M.C., A.U.S., who is now at the Army Air Forces Redistribution Station in Atlantic City awaiting a new assignment after 33 months overseas, has been awarded the Bronze Star. Colonel Beard was Senior Surgeon for the 19th Tactical Air Command which gave air support for General Patton's army.

A Bronze Star has also been awarded Captain Clarence R. Hartman, M.C., A.U.S., Surgeon, Company E, 5th Engineer Regiment and 26th Signal Construction Battalion, for his service as unit surgeon overseas in Iceland, England and France.

Lt. Comdr. Wesley Fry, M.C., U.S.N.R., has returned to the United States for reassignment after almost two years of duty in the Pacific. Comdr. Fry was stationed at the Naval Medical Center, Bethesda, from early 1942 until he left for overseas in July of 1943 as senior medical officer of the U. S. S. *Chester*. His ship engaged in the battles of the Marshall, Elice, Gilbert and Caroline Islands, Leyte Gulf, Palau, the Mariannas, Iwo Jima and the Aleutians. He was in the Philippines before returning for reassignment.

LETTERS FROM MEMBERS IN THE SERVICES

From Major Karl C. Corley, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: Have landed in Germany as part of the 7th Army and wanted to let you have my new APO number. After getting around some of the units in the forces overseas, especially those which have come up through Africa, Italy and France, I feel like small potatoes for having come over so late.

The thousands upon thousands of liberated Allies who were prisoners and the forced labor population which is being uncovered in the advance through Germany are providing a tremendous problem to the U. S. Army and UNRRA. Many of them are in bad shape from malnutrition and maltreatment.

From Captain A. M. Wheeler, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: My failure to write certainly does not indicate any lack of appreciation of your efforts in behalf of the medical man overseas, rather, a lack of subject material to clutter up your desk. Your last letter was excellent and many, even non-Washingtonians, enjoyed it. I have 124 points to return but I've decided and been reassigned to the Pacific Theater. So I am writing only to give warning of a change in address which will follow.

I had continuous service with the 1st Armored Division until August. Then I went with the Roosevelt unit. They are a grand bunch to work with but I'm combat-conscious and expect to get in my feeble licks at the Jap.

From Captain Joseph E. Brackley, c/o Postmaster, San Francisco, Calif.:

Dear Mr. Wiprud: Having just received the notification of election to the Society, it looks as though the three-month period for reply has considerably more than elapsed. The result, I trust, will not be disastrous. The delay in arrival is undoubtedly due to a change in organization which I trust you will note above. I am widely traveled these days (who isn't) and this also played some part. . .

Needless to say, I feel quite honored to be made a member of the Society and heartily wish for the day when I may again be in Washington to attend the meetings.

From Captain Camp S. Huntington, c/o Postmaster, San Francisco, Calif.:

Dear Mr. Wiprud: I hope you will pardon this paper but writing materials are a critical item in this theater.

I just wanted to drop you a line and let you know that after 32 days at sea I finally arrived in Manila early in April and after banging around in a replacement depot for a month was eventually assigned to this headquarters as assistant surgeon. There is actually very little professional work, our main job being the coordination and supervision of medical care and records in the Pacific theater depots.

The "Flips" (Filipinos) are very friendly but are universally of the (somewhat erroneous) opinion that all Americans are "reech." As a result the prices for the simplest native items are just about out of this world. For example, our pump-jack used in pumping water from a deep well to a

storage tank broke. Two "Flips" offered to loan us an excellent pump-jack which they had acquired. After a good deal of trouble and work it was installed. A week later they decided they wanted it back! The only other alternative was to buy it for 1400 pesos (\$700.00)! They got it back pronto and we are hauling our own water!

I would appreciate it greatly if my copy of *Medical Annals* could be sent to me at the above address. I certainly like to keep in touch with all that goes on.

From Major Howard Katzman, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: I am now assigned as Chief of Anesthesia at the above hospital which is located in Northern Burma. The hospital has been in the C.B.I. theater for some time but recently moved into Burma last month. The wards and operating rooms are all tents but the efficiency seems to be unimpaired. We are near a village which was the scene of some of the bitterest fighting against the Japanese and there are no buildings left untouched by the terrific air bombardment.

This is my second tour of foreign service, since I spent twenty-seven months in Panama after Pearl Harbor. It seems that I cannot get my desire for cooler weather. The climate in Burma is like Washington in August, a fact Washingtonians dislike to mention.

My living conditions are rather primitive since I live in a tent with no chair or table. I do, however, have a bed with a mattress and pillow. Upon my arrival in India, I spent nearly three weeks in a replacement camp with a bed without mattress, pillow or linens. It is an interesting experience for it makes one appreciate the comforts which we have taken for granted.

I truthfully miss my copy of the *Annals* and would appreciate your changing my address to the above hospital and sending me this journal and your interesting letters.

From Major Raymond Maret, c/o Postmaster, New York, N. Y.:

My dear Mr. Wiprud: Got a copy of February's *Annals* today and after seeing some of the letters in your War Section, felt impelled to add my two cents. After spending ten months in England, I was suddenly flown direct to Germany about three weeks before V-E Day, in command of a team to take over some kraut Wehrmacht hospitals that were captured and overrun by our surging armies. Set up my headquarters in Limburg/Lahn, a city about 35 per cent bombed out. Our transport consists of excellent former Nazi cars, our quarters are in an excellent hotel we requisitioned, and our work is most interesting. I've about 4,000 beds in my area, and after two months in the middle of heinie medicine and surgery, I can thank God for our American system. Apparently the German doctors are about eight years behind in medicine; one oberst, or L.C., told me they were more interested in maintaining party standards than scientific ideas. Their surgery, my colleagues tell me, is barbaric—joints are excised readily and pus is everywhere—even the most modern of their hospitals has a very distinctive aroma. Penicillin is unknown

to them, they still use the earliest sulfa drugs, and diphtheria and T.B. are common diseases. Incidentally, of the hundreds I've spoken to, I've yet to meet an admitted Nazi.

From Captain J. Phelps Hand, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: I want to tell you how much I enjoyed the last issue of the news letter and also apologize for not answering the questionnaire as to what we in the service intend to do after the war. Somehow or other that seemed so far off and in the press of work I put it aside. Now I seem to have lost it but anyway I expect to be seeing you in person before too long a time has elapsed and I guess I can answer any questions at that time.

I finished up the Italian campaign with an assignment as Chief of Anesthesia in a newly formed Evacuation Hospital and we had a very busy time of it in April and May as we rushed across Northern Italy going from Leghorn all the way to Trieste. There was never a dull moment and I more than had my hands full. I've never worked that hard in all my life and I hope I don't ever have to again.

I got a letter the other day from Bev. Smith and he told me that he had been surprised to pick up the *Annals* and see that picture of us staring him in the face. My copy hasn't caught up with me so I knew nothing about it either. At least I'm prepared now and will open the next copy with caution.

My regards to everyone and I hope to see you soon.



LT. COLONEL SUTTENTFIELD (left) WITH HIS UNIT IN RHINE CROSSING

From Lt. Colonel F. Daniel Suttentfield, c/o Postmaster, New York, N. Y.:

Dear "Uncle" Ted: I think you will find the enclosed snapshots amusing. They were taken the first day our Army crossed the Rhine. Of course we were bombed, shelled and strafed but the crossing was wonderfully smooth in general. "Smoke screens disclose the area you're in but not your exact spot."

It is about time one of your good letters is due. I'm anticipating same.

We are frightfully busy. I'm an area surgeon for a large military district—something like a state or district health officer in the good ole U.S.A., as public health is also now under military control.

P.S. Europe is really snafued!

From Captain Don S. Knowlton, c/o Fleet Post Office, San Francisco, Calif.:

My dear Ted: I haven't received any news from you for some time and frankly have missed it. We have been on the move since 15 March, 1945. The Sixth Marine Division, Fleet Marine Force, hit the beach at Okinawa, Prefecture of Japan, on 1 April, and my division swung north and covered eighty-four miles and captured over five hundred square miles of territory, taking in four-fifths of this island. Next we were ordered south to take over one-half of the Army line and finish the job. We have been in action fifty-five days today, and it has been rugged going, up hill and down dale, rain, warm days and cold nights, impassable roads, blown bridges, and a hell of a mess generally.



CAPTAIN KNOWLTON WITH THE MARINES
AT OKINAWA

However, this is so much different than the battle for Guadalcanal, B.S.I., as that was a tin can expedition compared to this. Now we have everything, more Navy out here than I ever dreamed of, the finest air force in the world, Army, Navy, and Marine Corps, and a combat team in action here that can't be stopped. The issue has never been in doubt since we landed, and the end is now definitely in sight.

I am very proud of the medical department of this division. It has turned in a beautiful score. All my officers and men have demonstrated a high degree of efficiency, and have been commended for their work. This Army out here is all right and have been fine comrades in arms. As regards the Marines, they are "hot as a bunch of firecrackers."

It doesn't seem possible that I have been out here ten months on my second tour of duty in the Pacific. Time certainly passes swiftly by, and with Germany out of the way and Japan on the ropes, I am already planning to return to

Washington and resume my practice which I left five years ago. We are all in fine spirits out here, bright-eyed and bushy-tailed, and are just waiting for the right moment when we can land on the mainland of Japan, and march up the streets of Tokyo with the Stars and Stripes at the head of the line.

You have as always my warmest personal regards. Please remember me to my good friends in Washington, and tell Colonel Whitmore that young Manion has done a fine job out here. I am enclosing a picture that was taken by the Public Relations office here on this island a few days ago. Possibly you can recognize it.

From Commander Henry A. Monat, St. Albans, Long Island, N. I.:

Dear Theodore: A bit of interesting news for you as you have read in the paper about our baby carrier catching a German submarine—Well, I was Senior Medical Officer on that carrier, and the carrier's name is the GUADALCANAL.

Believe me, it was a tremendous pleasure catching those krauts on their submarine and needling them and showing them New York German papers with news that made them shiver from head to feet.

My Skipper tells me that in the future they will show the complete movies of the capture, not the fragmentary version shown in the Trans-Lux Theatres last week.

I am still at St. Albans in charge of Bellyache Work.

From Lt. Colonel F. Daniel Suttentfield, c/o Postmaster, New York, N. Y.:

Dear Ted: The April issue of MEDICAL ANNALS has been received, read and re-read. However, I note that my letter to you was published in this issue and not Major General Manton S. Eddy's to me. I fear those who read the letter will get the idea that I'm tooting my own darn horn which I most certainly didn't intend to do. Do you not think General Eddy's letter should be published to counteract such?

This section of the world is beautiful but it has scars of war which perhaps cannot be erased within this century. . . .

EDITOR: Most certainly! Here it is:

MY DEAR COLONEL SUTTENTFIELD: I cannot tell you what a wrench it is to relinquish command of the XII Corps. Today the doctors have ordered me to return to America for rest.

Before I leave, I want you to know of my admiration for your splendid troops and of my gratitude for their magnificent contribution to the successful operations of our Corps. The achievements of our Corps Medical Troops is surely a tribute to modern science and to human courage.

Please accept for yourself, and convey to your command, this expression of appreciation. I wish I could be with you for the kill. Good luck—and Godspeed!

Sincerely yours,

s/ M. S. Eddy

Major General, U. S. Army
Commanding

(Continued on page 335)

On The Home Front

At the 124th Annual Commencement of **George Washington University**, May 30, President Cloyd Heck Marvin departed from the usual ritual when he stepped aside to allow five men, two of them members of the Medical Society, to present diplomas to members of their families. **Dr. Coursen B. Conklin**, Clinical Professor of Medicine, conferred a medical degree upon his son, Coursen B. Conklin, Jr. **Dr. Tomas Cajigas**, formerly Professor of Pathology, also presented his son, Tomas Robert Cajigas, with a degree in medicine.

The Class of 1945 in the School of Medicine numbered 73. They pledged themselves to contribute \$14,600 to the Medical School's endowment fund, begun by the Class of 1940, subscriptions to which now total \$90,000.

Thirty-nine members of the class were commissioned First Lieutenant in the Army of the United States; 21 were commissioned Lieutenant (j.g.) in the United States Naval Reserve.

The degree of Doctor of Medicine was conferred upon 87 graduates of **Georgetown University School of Medicine** at the University's 146th Annual Commencement, June 17. Of this number 57 were commissioned First Lieutenant in the Army of the United States, and 24 received the commission of Lieutenant (j.g.) in the United States Naval Reserve.

At the commencement exercises, the Very Rev. Lawrence C. Gorman, S.J., President of Georgetown University, awarded the honorary degree of Doctor of Laws upon **Vice Admiral Ross T. McIntire**, Surgeon General of the Navy.

The Section on Pediatrics met June 21 in the Society's building. Drs. John L. Parks and Lewis K. Sweet collaborated in presenting "Abnormalities of the Ovum and Fetus; Seven Years' Observation at Gallinger Municipal Hospital."

The American Typhus Commission Medal has been awarded to three local medical officers. Lt. Stafford M. Wheeler, U.S.N.R., was awarded the medal posthumously for his typhus-control program in Yugoslavia, where he was killed by the explosion of a land mine. His widow, Mrs. Anne Bolling Wheeler, resides at 7811 Stratford Road, Bethesda, Md.

The second recipient of the award was Colonel William L. Wilson, 4425 River Road, N. W. As deputy director of the Public Health Section, Supreme Headquarters, Allied Expeditionary Forces, he labored among refugees and displaced persons in Northwestern Europe.

Lt. Colonel Emory C. Cushing, 1802 North Oak Street, Arlington, Va., was cited for his work in France during 1944 and 1945, which contributed to the general reduction of typhus in the Western European combat zone.

Attention is again called to the plea of the **Army Medical Library** for contributions in the way of standard medical publications to replace scientific periodicals which have been destroyed in devastated countries and to build up libraries in countries which are less favored than ours. Members having periodicals which they would like to contribute may deliver them to the Society's office, where they will

A NEW SERVICE

The District of Columbia Tuberculosis Association through its recently developed BUREAU OF INFORMATION offers

Information in relation to Health and Community Services in the control of tuberculosis in the District of Columbia.

Assistance in how best to use all available diagnostic facilities, such as X-ray equipment, sputum examinations, etc.

Literature on tuberculosis—Diagnostic Standards, X-ray Interpretations, booklets and pamphlets on family health education for office distribution to patients.

Health Education for patients and families upon referral.

FOR THIS SERVICE, write or phone The District of Columbia Tuberculosis Association, Rebecca Sweeney, R. N., Secretary, Bureau of Information, 1601 18th Street, N.W., Telephone Adams 7100.

be picked up by the Library. The journals particularly desired are the *American Heart Journal*, *Journal of Diseases of Children*, *American Journal of Tropical Medicine*, *Annals of Internal Medicine*, *Archives of Dermatology and Syphilology*, *Surgery, Gynecology and Obstetrics*, and *War Medicine*.

General Omar Nelson Bradley, American deputy to General Dwight D. Eisenhower, was appointed **Administrator of the Veterans Bureau**, June 7, by President Truman. He will succeed **Brigadier General Frank T. Hines**, who took office under President Harding and has served continuously for 22 years.

General Bradley, who commanded about one million American troops in France after D-Day, is known as the "doughboy's general." As Commander of the 2nd Corps he fought in the Northern Tunisian Campaign. He commanded the 12th Army during the German counterattack in the Belgian bulge and the American capture of the Remagen bridgehead. In 1943 he was awarded the Distinguished Service Medal.

Dr. Alvin R. Sweeney of the United States Public Health Service, formerly head of the Marine Hospital in Cleveland and medical officer for the Ninth Naval District, became **Superintendent of Gallinger Municipal Hospital** on July 6.

Dr. Sweeney was born in Grand Chenier, La., September 2, 1881. He received his medical degree from Jefferson Medical College, Philadelphia, in 1908. After interning at Jefferson Hospital, he returned to Lake Arthur, La., to engage in private practice. In 1913 he was commissioned Assistant Surgeon of the U. S. Public Health Service for immigration duty at Ellis Island, New York.

In 1915 he was assigned to the Marine Hospital at St. Louis. From 1915 to 1919, during World War I, he was in charge of public health programs relating to cantonment areas at Fort Worth, Chattanooga, and Fayetteville, N. C. He served in various assignments since that time and in June 1938 went to Ellis Island as executive officer in charge of the Marine Hospital there. In 1942 he was transferred to the Marine Hospital, Cleveland. He now carries the rank of Medical Director in the U. S. Public Health Service. He will retire October 1 as head of the hospital in Cleveland.

NEW AUXILIARY PRESIDENT



MRS. WILLIAM EARL CLARK

President, Woman's Auxiliary to the Medical Society of the District of Columbia, 1945-1946

Dr. Sweeney has always been keenly interested in tuberculosis control work. In Cleveland he was Associated with the Anti-Tuberculosis League. He conducted a campaign in that city that was responsible for the mass chest X-raying of 100,000 war workers.

The post of Superintendent of Gallinger Hospital has been filled during the past 18 months by **Dr. Daniel L. Seckinger**, Deputy Health Officer.

Dr. John F. Owen, Chief of the District Health Department's new **Mental Hygiene Bureau**, submitted his resignation, June 4, after serving in that capacity for approximately one month. Disappointment over lack of personnel, office space and clinic facilities for his position was given as the reason for his resignation. Dr. Owen has returned to Raleigh,

N. C., where he was formerly Superintendent of the State Hospital.

Dr. Herbert P. Ramsey, Chairman of the **Washington Metropolitan Health Council**, announced the appointment, June 9, of a three-man "board of surveyors" to direct the health and hospital survey of the Metropolitan Area, which will include the District of Columbia, Prince Georges, Montgomery, Arlington and Fairfax Counties, and the City of Alexandria. The three members will be Professor C. E. A. Winslow and Colonel Ira V. Hiscock of New Haven, Conn., and Dr. Claude W. Munger of New York City. Professor Winslow is retiring as Pro-

President of the American College of Hospital Administrators.

The survey, which will begin September 1, will be conducted under the supervision of a Survey Committee of the Health Council, with Vice Admiral Ross T. McIntire, Surgeon General of the Navy, as Chairman. Facilities and present activities of health agencies, hospitals and clinics, both public and private in the Metropolitan Area, will be studied. The survey has the endorsement of the Community War Fund, the Washington Board of Trade, the Medical Society of the District of Columbia, the six health officers of the area, and the State Commissioners of Health of both Maryland and Virginia.



(Left to right) DR. RAMSEY, COL. HISCOCK, DR. WINSLOW, DR. MUNGER

fessor of Public Health at Yale Medical School and is Editor of the *American Journal of Public Health*. Colonel Hiscock, who will succeed Professor Winslow at Yale, has recently completed his tour of duty with the Civil Affairs Division of the U. S. Army. He received the Legion of Merit for distinguished service in prevention of disease among our troops overseas and in the field of sanitation. Colonel Hiscock has held the office of President of the National Health Council and is remembered in Washington for the active part he took in the health and hospital survey of 1929-30. Dr. Munger, Hospital Consultant and Director of St. Luke's Hospital, New York City, is a former President of the American Hospital Association and is now a member of the Council on Government Relations of that Association. He is also

The Georgetown Clinical Society held its annual outing, May 24, at the Bradley Hills Country Club, ending its activities with a dinner in the evening. Dr. George Tully Vaughan was guest of honor.

The following officers were elected to serve during the coming year at the annual business meeting, held at the Statler Hotel, March 20:

Dr. Raymond C. Kirchner, *President*; Dr. Walter K. Angvine, *Vice President*; Dr. Robert F. Costello, *Secretary-Treasurer*.

The Jacobi Medical Society elected the following officers for 1945-46 at its meeting, May 28:

Dr. Lester Neuman, *President*; Dr. Benjamin Golden, *Vice President*; Dr. Leon Gerber, *Secretary*; Dr. Edward A. Cafritz, *Treasurer*.

The Council on Physical Medicine of the American Medical Association, at its twentieth annual meeting in Chicago, February 11 and 12, took cognizance of the important problems currently arising in the field of occupational therapy because of war casualties by appointing a group of consultants. Those appointed were Dr. Winfred Overholser, *Chairman*, Dr. Raymond Allen, Colonel Howard A. Rusk, M.C., A.U.S., Dr. William Stroud and Dr. Francis Trudeau.

Dr. Roy D. Adams, who is a member of the Medical Advisory Committee of the Veterans Administration, was called to testify before the House Veterans' Committee, June 27, concerning the controversy over patient-care in veterans' hospitals. Others in like capacity called to testify were Dr. Max Cutler, Chicago; Dr. William F. Lorenz, Madison, Wisconsin.

sin; Dr. Malcolm T. McEachern, Chicago; and Dr. George N. Pierson, Philadelphia.

Dr. Henry H. Hazen was reelected June 12 to serve another term as President of the **District Social Hygiene Society**. Also reelected were Mrs. Laura Martin, Secretary, and **Dr. George W. Creswell**, Treasurer. Assistant Surgeon General J. R. Heller, U. S. Public Health Service, was appointed a new member of the Board of Directors.

Assisting James E. Colliflower, who is General Chairman of **Georgetown University's New Hospital Fund Campaign**, are several members of the Medical Society. **Dr. Joseph S. Wall**, Director of the Department of Pediatrics in the Medical School, is one of three Vice Chairmen as well as Chairman of the Medical Division. **Dr. William J. Stanton** is a member of the Executive Committee. **Dr. John B. Sullivan** will serve as a Vice Chairman under H. Gabriel Murphy, Chairman of the Community Division. The goal for the campaign is \$750,000.

Gallinger Municipal Hospital has been declared eligible by Comptroller General Lindsay Warren to receive funds under the Bolton Act for training cadet nurses.

Copies of the first two issues of a new publication, *Cadet Nurse Corps News*, has been received in the Society's office. The first issue, dated April 1945, featured a letter which Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, addressed to the Cadet Nurses, announcing the inauguration of the *News* as the official organ of the Cadet Nurse Corps and expressing appreciation on behalf of the U. S. Public Health Service for the excellent record the Corps has made.

Dr. Edgar Garrison Ballenger, President of the **Southern Medical Association** and of the Georgia Urological Association, died from a fall sustained at the Georgian Terrace Hotel, June 1.

Dr. Ballenger was born November 20, 1877, in the Blue Ridge mountains near Tryon, North Carolina. He received his degree in medicine from the University of Maryland in 1901. During World War I he was Chief Urologist of the 26th Division. For many years he was Professor of Urology at Emory University. Instrumental in organizing the Southeastern Surgical Congress in 1930, he became its first President. He was Past President of the American

Urological Association and held fellowship in the American Medical Association and the American College of Surgeons.

Dr. E. Vernon Mastin, St. Louis, Missouri, elected Vice President of the Southern Medical Association at the last annual meeting, became President of the Association upon the death of Dr. Ballenger.

Dr. Oscar B. Hunter attended the meeting of the Executive Committee of the Council of the Southern Medical Association in Birmingham, Alabama, May 21. Dr. Hunter is the immediate Past Chairman of the Executive Council. In the evening he presented a paper on "The Clinical Significance of the Rh Factor" before the Jefferson County Medical Society. Following the scientific program the Southern Medical Association was host to the Jefferson County Medical Society and visitors for a social hour.

Dr. William C. Woodward is serving as a member of the Committee on the Rights of the Mentally Ill of the American Bar Association. This Committee is studying the system which has been in use in the District of Columbia since 1938.

Dr. Lawrence E. Putnam discussed "Recent Experiences with Various Penicillins" before the staff of the Bureau of Venereal Diseases of the District Health Department, June 23. The meeting was held at the Polk School.

Several members of the Society who have served in this country and overseas were recent visitors at the Society's office. Among them were **Lt. William K. Billingsley, Jr., M.C., U.S.N.R.**, **Captain Peter Paul Brue, M.C., A.U.S.**, **Lt. Colonel George Dewey, M.C. A.U.S.**, who has recently been discharged from service, and **Major Thomas E. Mattingly, M.C., A.U.S.**

Dr. Jacob J. Weinstein addressed two groups recently. On June 10 he spoke before the District of Columbia Podiatry Society at the Washington Hotel on "Foot Infections and the Use of Penicillin, Sulfones and Tyrothricin Locally and Systemically."

He read a paper before the Prince Georges County Medical Society at Cheverly Hospital, June 6, on the subject, "Protein Metabolism in Surgical Patients and the Parenteral Use of a Protein Digest Solution."

Dr. James A. Gannon, member of the Board of Education, presided at the graduating exercises of Langley Junior High School, June 19.

Dr. J. Walter Bernhard was installed as President of the **District Dental Society**, June 12, at a meeting held in the Medical Society's auditorium. Dr. Bernhard has served as the Dental Society's Secretary-Treasurer for the last six years and as Treasurer of the Five-State Postgraduate Clinic for four years. **Dr. Joseph A. Madden**, the new President-elect, will take office as President a year from now.

Sir Alexander Fleming, eminent British scientist, is in the United States for a short visit, during which he will meet scientists in various parts of the country and will visit the larger hospitals where penicillin is being used. At a press conference in Washington, June 4, at the British Information Services, he related the story of the discovery of penicillin and the possibilities for its future widespread application in the treatment of infections and diseases. Representing the **MEDICAL ANNALS** at the press conference was its Managing Editor, **Theodore Wiprud**. Sir Alexander spent several hours at Walter Reed Hospital.

The Passano Foundation, Inc., of Baltimore presented the First Passano Award to Dr. Edwin Joseph Cohn, Professor of Biochemistry at Harvard University, at the building of the Medical and Chirurgical Faculty of the State of Maryland, May 16. The title of the address delivered by Dr. Cohn for the occasion was "The Chemical Separation and the Clinical Appraisal of the Components of the Blood." The recipient of the award received a check for \$5,000.

Waverly Press, Inc., which was founded and is still owned and operated by the Passano family, received the Navy Commendation Award for Printers for "outstanding performance and service rendered to the United States at war." Presentation ceremonies for the management and employees of Waverly Press and invited guests were held at the Alcazar Hotel, Baltimore, July 1.

The **MEDICAL ANNALS**, as many of our readers know, is printed by the Waverly Press, which is devoted exclusively to the printing of scientific publications.

Schenley Laboratories, Inc., is presenting a series of national broadcasts over the Columbia Broadcast-

ing System, entitled "The Doctor Fights," on Tuesday evenings at 9:30 p.m., EWT. The series, which began June 5 and will continue for twelve additional weeks, will feature motion picture stars in half-hour dramatizations of the actual feats accomplished by medical officers of the armed forces during World War II. It is planned where possible to have the actual surgeons or physicians whose deeds will highlight the program appear in person. Sir Alexander Fleming, discoverer of penicillin, was guest on the radio series, July 3.

CORRESPONDENCE

WASHINGTON, D. C., May 17, 1945

MR. THEODORE WIPRUD, SECRETARY
MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA
1718 M STREET, N.W.
WASHINGTON, D. C.

DEAR MR. WIPRUD:

My attention has been called to the fact that the Narcotic Bureau has renewed its campaign against the practice of physicians phoning narcotic prescriptions to the pharmacist. The Bureau maintains that present conditions brought about by a shortage of physicians and the consequent effort to save time does not constitute a valid excuse for violation of the regulations under the Narcotic Act.

Regardless of the inconvenience caused the physician all prescriptions calling for narcotic drugs must be written in proper form and signed by the physician before the medicine is delivered to the patient. In this connection the law is explicit and states in Chapter VIII Article 171, "The furnishing of narcotics pursuant to telephone advice from practitioners is prohibited, whether prescriptions covering such orders are subsequently received or not, except that in an emergency a druggist may deliver narcotics through his employee or responsible agent pursuant to a telephone order, providing the employee or responsible agent is supplied with a properly prepared prescription before delivery is made, which prescription shall be turned over to the druggist and filed by him as required by law." From the above quotation it will be noted that the law provides no exceptions to the regular procedure for handling narcotic prescriptions. In cases of extreme emergency only, the physician may leave a written prescription with the patient to be surrendered when the medicine is delivered. For a physician to telephone the order to the pharmacist and mail the prescription subsequent to the delivery of the medicine is a direct violation

of the law and is furthermore an injustice and imposition on the pharmacist, he being the individual liable for prosecution under the law.

Will you please call this matter to the attention of the members of the Medical Society, so that there will be no misunderstanding in the matter when local pharmacists refuse to take narcotic prescriptions over the telephone.

Very truly yours,

HAROLD C. KINNER

*Secretary, The District of Columbia
Pharmaceutical Association, Inc.*

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review. After the reviews have been published the books will be placed in the New Book Section in the Medical Society's Library. There they may be examined at leisure but cannot be removed from the building.

Technical Methods for the Technician. ANSON LEE BROWN, A.B., M.D., Director of Dr. Brown's Clinical Laboratory and Dr. Brown's School for Technicians, Columbus, Ohio. Price, \$10.00. Pp. 706. Columbus, Ohio: A. L. Brown, 1944.

Men Under Stress. ROY R. GRINKER, Lt. Colonel, M.C., A.U.S., Graduate of the University of Chicago and Rush Medical College; former Fellow of the Rockefeller Foundation; formerly Chairman of the Department of Neuropsychiatry of the Michael Reese Hospital; AND JOHN P. SPIEGEL, Major, M.C., A.U.S., formerly of the Department of Psychiatry of the Michael Reese Hospital. Pp. 484. Philadelphia: Blakiston, 1945.

Rypins' Medical Licensure Examinations; Topical Summaries, Questions, and Answers, 5th ed., edited by WALTER L. BIERRING, M.D., F.A.C.P., M.R.C.P., EDIN. (HON.); Member, National Board of Medical Examiners; Secretary, Federation of State Medical Boards of the United States, WITH THE COLLABORATION OF A REVIEW PANEL. Price, \$6.00. Pp. 546. Philadelphia: Lippincott, 1945.

A Guide on Alcoholism for Social Workers. ROBERT V. SELIGER, M.D., Assistant Visiting Psychiatrist, Johns Hopkins Hospital; Instructor in Psychiatry, Johns Hopkins University Medical School; Medical Director, Haarlem Lodge, Catonsville, Md., and The Farm

for Aleoholic Patients, Howard County, Md.; Executive Director, The National Committee on Aleohol Hygiene, Inc., in collaboration with VICTORIA CRANFORD, Psychotherapist and Rorschach Analyst, Haarlem Lodge; Director of Seientifie Investigators, The National Committee on Aleohol Hygiene, Inc. Price, paper, \$2.00. Pp. 94. Baltimore: Aleoholism Publications, 2030 Park Ave., 1945.

Life Overflows. An original serapbook arrangement of soothing philosophical thoughts. CARL LEONARD THENEBE, M.D. Price, \$2.50. Pp. 116. Boston: Bruce Humphries, 1944.

Hayfever Plants; Their Appearance, Distribution, Time of Flowering, and Their Role in Hayfever, with Special Reference to North America. ROGER P. WODEHOUSE, PH.D., Associate Director of Research in Allergy, Lederle Laboratories, Pearl River, New York. Price, \$4.75. Pp. 245. Waltham, Mass.: Chronica Botanica Co.; New York: Steehert, 1945.

BOOK REVIEWS

Clinical Roentgenology of the Digestive Tract, 2nd ed. MAURICE FELDMAN, M. D., Assistant Professor of Gastroenterology, University of Maryland; Assistant in Gastroenterology, Mercy Hospital; Consulting Roentgenologist, Sinai Hospital. Price, \$7.00. Pp. 769, with 550 illustrations. Baltimore: Williams & Wilkins, 1945.

This, the second edition, covers in a most complete manner the roentgen diagnosis of all lesions in the gastrointestinal tract and biliary system as well as allied intra-abdominal pathology.

It is recommended as an excellent reference book for the internist as well as the radiologist.

E. M. MCP.

Medical Uses of Soap—A Symposium, edited by MORRIS FISHBEIN, M.D. Price \$3.00. Pp. 182 with 41 illustrations. Philadelphia: Lippincott, 1945.

This is a thorough discussion of the various uses of soap and soap substitutes as related to the practice of medicine.

There is a certain amount of repetition which might have been omitted, particularly in the discussion of soap chemistry by the various authors and in the discussion of the cause of soap irritation.

To the reviewer the most valuable sections were those on soaps for industry by McCord and on Cutaneous Detergents other than soap by Lane and Blank.

The book is well bound, printed on good paper, and easily readable.

Medical Uses of Soap may be recommended to all physicians and particularly to dermatologists and industrial physicians.

F. J. E.

Industrial Ophthalmology. HEDWIG S. KUHN, M.D. Price, \$6.50. Pp. 294. St. Louis: Mosby, 1944.

A competent understanding of Industrial Ophthalmology is necessary toward safeguarding the life and limb of workers, reduction of time and of production loss due to accidents, and waste of material due to visual defects. The present speed-up of industry has emphasized all this. Despite mechanical safety devices, accidents still have a way of happening. Despite precision equipment, materials and time still are wasted.

Author Kuhn has written a volume which is comprehensive, authoritative, presented in a very plain and readable manner, and delightfully brief. It is remarkably free from difficult phrasings and technicalities.

The volume first considers the basic general visual tests used in industry, with the reasons for each. Emphasized is the need of bringing the right man—or perhaps let us say the right pair of eyes—and the right job together. Following this is a concise description of the correction of visual defects in so far as is practicable, whether it be simple lenses, prisms, or orthoptic exercises.

The section on Industrial Accidents is written by Dr. Albert C. Snell. A general classification of eye injuries is offered, with reference to the anatomy involved and general types of accidents. Emergency relief is taken up and then follows a concise and lucid description of subsequent treatment of these injuries.

The latter portion of the book takes up the matter of a program of industrial eye protection and deals with goggles, illumination, shields from "flashes," fluids and solids cast up toward workers' faces in industry. A brief survey of the medicolegal aspects of industrial eye accidents follows.

The book ends with mention of some recent developments, such as keratoconjunctivitis (epidemic), the employment of the blind in industry, and rehabilitation.

Excellent photographs made right in the factory occur freely; also fine graphs to illustrate statistics. Few volumes offer so much pleasant and profitable reading in as few pages. For the ophthalmologist, whether industrial or one in civil life, this is a "must" book.

S. A. M.

A Textbook on Pathology of Labor, The Puerperium and The Newborn. CHARLES O. McCORMICK, A.B., M.D., F.A.C.S., Clinical Professor of Obstetrics, In-

diana University School of Medicine; Consulting Obstetrician to William H. Coleman Hospital for Women, Indianapolis City Hospital, and Sunny Side Sanitarium. Price, \$7.50. Pp. 399, with 191 illustrations. St. Louis: Mosby, 1944.

As noted in the preface, this book is an outgrowth of a series of lectures given by the author to students at Indiana University. It is presented in outline form which makes it especially easy to cover any given subject in a few minutes. For this reason it should be valuable to the individual who occasionally likes to spend a few minutes reviewing some problem confronting him. Important items are stressed by printing them in heavy black type that makes them readily found. This includes things important to do, as well as not to do.

In the section on puerperal infection the author does go into some detail about Holmes and Semmelweis. This is always an interesting part of obstetrics and is stimulating to the student who reads it. The book is recent enough to mention penicillin and give an outline on the use of it.

In the section on analgesia he not only gives the method that bears his name but other well recognized technics. The one about paraldehyde was contributed by Dr. Howard Kane.

The book ends with a list of fifty obstetric aphorisms which warrant considerable reflection. Intelligent waiting is better than watchful waiting and *non vi sed arte* (not strength but art) are given as examples.

L. L. C.

Yellow Magic, The Story of Penicillin. J. D. RATCLIFF. Pp. 173. Price, \$2.00. New York: Random House, 1945.

In the final sentences of his book, the author justifies his selection of the title, "Yellow Magic," by quoting Sir Alexander Fleming, who was knighted and awarded membership in Britain's Royal Society for his contribution to human well-being: "People have called penicillin a miracle. For once in my life as a scientist, I agree. It is a miracle which will save lives by the thousand."

Dr. Chester Keefer, Chairman of the National Research Council's Committee on Chemotherapeutic and Other Agents, who had the tremendous task and responsibility of assay and administration of penicillin in the early days of production, paraphrases Churchill in the foreword when he writes: "There is no other drug that is able to do so much for so many diseases."

The Story of Penicillin is an intensely fascinating narrative which begins with the account of a bacteriologist who never forgot the unfruitfulness of his search for a better wound antiseptic in the last war. In 1928 Fleming

saw his cultures of staphylococci “contaminated” by a bit of green mold (*Penicillium notatum*) and had “the good sense to perceive its full implications.” His carefully recorded observations, duly set forth in the *British Journal of Experimental Pathology* for June, 1929, lay forgotten for ten years until Dr. Howard Walter Florey of Australia, graduate and faculty member of Oxford, chanced to read the original paper and carried forward the discovery of penicillin by isolating the chemical.

During England’s dark days of 1941 Florey and Heatley, a fellow scientist, journeyed to the United States to interest American scientists and laboratories in the large scale manufacture of a miraculous drug whose total yield, after a long time-consuming process, at a cost of tens of thousands of dollars, was one level teaspoonful!

From then on the story gathers momentum. By the combined efforts of scientists and commercial laboratories (and the roll of honor for both is a long one) the prodigious task was accomplished whereby the seven years usually necessary for a laboratory discovery to emerge as a product were squeezed into months. This story of coöperative effort, unparalleled in history, will occupy a unique place in the annals of World War II.

Several chapters in the book are devoted specifically to the new outlook which the use of penicillin brings to bear on syphilis, gonorrhea and wounds of war.

Mr. Ratcliff writes with an enthusiasm which is transferred to the reader. Every cubic inch of soil contains a universe of potentialities. As Dr. Morris Fishbein predicts in the introduction, penicillin has ushered in an epoch of antibiotics.

A. L. E.

Rabies—Ellicott

(Continued from page 324)

trict of Columbia, where no general vaccination plan was carried out.

	MONTGOMERY COUNTY	PRINCE GEORGES COUNTY	DISTRICT OF COLUMBIA
1944 prior to June 1	65	55	82
1944 after June 1	5	27	66
1945 prior to June 1	2	22	87

The last Montgomery County cases occurred in February 1945. One was a cat in Wheaton, the last infected area of the County. The other was a Dis-

trict of Columbia dog which ran away and was picked up in Westmoreland Hills near the D. C. line.

In retrospect, a still better plan would have been to institute dog vaccinations as soon as rabies had gained a foothold. Because of the existing stray and unwanted dogs, the dog-catching program and dog quarantine should also have been carried out. For the first year the quarantine should have applied to both vaccinated and unvaccinated dogs; otherwise, the dog-catching program would have been difficult. Even these measures would probably not have cut short the epidemic, but they would have greatly decreased its severity and reduced the risk to humans. It would have been necessary to repeat the dog vaccinations for several consecutive years.

The objective in rabies control is complete eradication. There are no rabies’ carriers. The disease stops with the death of the last infected animal. Eradication is easily possible if all communities in an infected area will coöperate in carrying out dog vaccinations and other measures known to be effective.

For information concerning Prince Georges County and the District of Columbia, the writer is indebted to Dr. A. L. Brueckner, Acting Director, Animal Disease Control, College Park, Maryland; Dr. George Byers, Jr., Health Officer of Prince Georges County; and Dr. James G. Cumming, Director, Division of Communicable Diseases, District of Columbia Health Department.

War Section

(Continued from page 327)

From Commander W. Warren Sager, c/o Fleet Post Office, New York, N. Y.:

Dear Mr. Wiprud: I have been in Brooklyn since the first of the month helping to outfit the vessel of which I am Chief Surgeon, and except for being away from my family, am thoroughly enjoying it. As you probably know, they have 802 beds and of course can add to these. They are air-conditioned throughout.

There is one very fine Washington boy aboard, a surgical technician named Goodrich whose parents live close to my family. He was at the Medical Center before coming here.

I have been seeing Captain Newhouser, whose family lives in Bethesda and who considers himself a Washingtonian, Charles Thompson, son of Dr. Lawn Thompson, and Dr. Caulk daily.

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

1945-1946

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THE CLINICAL VALUE OF PHYSICAL MEDICINE*

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THE ultimate aim of treatment is to alleviate suffering, lessen disability and, wherever possible, bring about a cure. With this in mind, it is the purpose of this third talk on physical medicine to point out the results that may be expected when it is employed in those diseases and conditions in which experience has shown physical therapy to be of definite clinical value. Such comments as follow are not based upon the extensive experience of one skilled in the art of physical medicine. They represent rather the observations of a clinician whose interest in this field of special therapy rests upon a firm conviction that it possesses possibilities until now but little appreciated by the majority of the medical profession.

It must be conceded that until recently physicians have shown little interest in or appreciation of physical medicine. The reasons for this attitude, which are not hard to find, have been repeatedly discussed and need no further elaboration.¹ Before emphasizing the value of physical medicine it may be of advantage to point out certain misconceptions that have militated

against its more widespread use and which at times have led to inaccurate evaluation of the results of physical therapy.

Physicians who employ or prescribe physical therapy should at least be possessed of a fundamental knowledge of the subject. It is unnecessary to be expert in the various procedures employed in physical therapy, but indications and contraindications for their use, their underlying basic physics and the physiologic alterations which they bring about should be understood. That such knowledge is possessed by only a limited number of physicians is in part due to the almost complete absence of this subject from the curricula of our medical schools, an omission which, it is gratifying to note, is now being corrected. Without a working knowledge of the subject, the practicing physician is at a disadvantage when it comes to writing a prescription for physical therapy. Instead of prescribing specifically the form of treatment desired, the average doctor is forced to delegate this to some nonmedical individual and to be content to refer patients with such vague directions as "give physical therapy" or "institute the treatment you see fit" or, again, "employ heat and mas-

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sage," a term which in the minds of too many physicians is synonymous with physical medicine. Any experienced physical therapist, who is meticulous not to treat patients unless referred by a physician, will bear out the statement that requests for physical therapy much too often are couched in terms that are ambiguous and indefinite. In passing, it may be added that all too frequently such requests are not accompanied by even a diagnosis. The result is that the physical therapist is frequently placed in the anomalous position of having to assume diagnostic as well as therapeutic responsibility, prerogatives which should never be relinquished by physicians. As the result of indifference on the part of the medical profession, lay technicians gradually have been required to assume more and more responsibility in this field. The laity, long aware of the apathy of our profession to physical methods of treatment, frequently bypass the physician and seek directly the help of the physical therapist when in the mind of the patient this type of treatment is indicated. Such a situation is not entirely to the liking of many doctors who freely and at times with bitterness criticize those engaged in physical therapy for a condition of affairs for which physicians themselves are largely responsible.

A widespread misconception exists that good physical medicine can only be furnished with the aid of complicated paraphernalia and expensive apparatus. This idea has kept many physicians from entering into this field of therapy. Those who entertain such beliefs should be reminded of the statement made some years ago by Mock² who emphasized that 90 per cent of physical medicine in general hospitals consists of common sense and intelligent handwork and that elaborate apparatus and machine-therapy do not make a physical therapy department nor are they essential to its effective practice. Observation of the daily routine in a department of physical medicine that serves a general hospital will confirm the truth of this dictum. At the present time it is evident that more and more the

elaborate forms of mechanical therapy are giving place to such simple fundamental procedures as massage, muscle reëducation, therapeutic exercises, the application of heat, and hydrotherapy. Successful physical therapy depends more upon the physician or physical therapist having a well rounded knowledge of the physiologic reactions of the body to exercise, heat, water, light and electricity and how and when to employ these agents than upon an imposing array of equipment. Furthermore, a mastery of these simpler procedures that depend primarily upon the skill and dexterity of the operator makes for a wider application of physical therapy. These forms of treatment are readily available in the office or the home and are not dependent upon elaborate departments.

Considerable divergence of opinion among physicians as to the clinical value of physical medicine has served as a deterrent to the more general acceptance of this type of therapy. If there are those who express great skepticism as to the usefulness of physical therapy, there are others who enthusiastically advocate its widespread application and make exaggerated claims for its success. Such differences of opinion result from a lack of exact knowledge as to the indications for and the effects of the various technics employed in physical medicine. Such deficiencies exist because the practice of physical medicine in the past has been based more upon empiricism than upon unbiased, objective observations. If these differences of opinion are to be overcome, physical medicine must be placed upon a sound, scientific foundation. To accomplish this, chief reliance must rest upon research. That important phase of this subject has already been brought to your attention.

The efficiency of any type of treatment depends upon the results obtained. In the practice of physical medicine an accurate appraisal of the effect of various types of treatment is beset with inherent difficulties. Among the most obvious of these may be mentioned: 1.

Many acute conditions for which patients seek relief from physical therapy tend to undergo spontaneous recovery in a reasonably short period of time without any treatment. 2. The great majority of patients that receive prolonged courses of physical therapy are suffering from chronic diseases, the etiology of which is not too well understood, the symptoms of which are normally subject to wide variation and even to long periods of spontaneous remission. 3. Most patients are receiving other forms of therapy along with their physical therapy. 4. Finally, as is the case in any form of treatment that is being carried out upon human beings, the all-important psychologic factor must not be overlooked. Heretofore in the evaluation of various methods employed in physical medicine these difficulties have not always been given due consideration. Too often this has led to the dubious practice of basing opinions as to the value of treatment upon the impression of an observer or patient's statement of subjective improvement.

ROLE OF THE PSYCHIC FACTOR IN PHYSICAL MEDICINE

The role that the psychic factor plays in the practice of physical medicine deserves further emphasis. It is obviously subject to great variation. It is difficult to control, and its importance cannot be overemphasized. The very nature of the methods employed in physical medicine are such as to exert a marked psychologic effect upon many patients. It is well known that many patients react favorably to new forms of treatment, mechanical procedures, the use or even the proximity of impressive equipment, extra personal attention, and above all to the actual "laying on of hands." All of these factors may and do make definite impressions that cannot be discounted.

The vast majority that pass through a Department of Physical Medicine are suffering from obvious organic disease that may be definitely benefited by mechanical forms of treatment.

In this group the psychogenic factor is negligible or entirely absent. There are, however, many patients that benefit from physical therapy who, in addition to the conditions from which they suffer, present evidences of a psychoneurotic overlay. To this type of patient the benefit from any form of treatment is tremendously enhanced by suggestion and proper psychologic therapy. For this reason it is important that the well trained physiotherapist should have received good psychologic training so that he or she may combine physical therapy with sound psychologic help.

The records of any Department of Physical Medicine will furnish numerous examples illustrative of this point. There was recently referred to us an able-bodied, successful, middle-aged gentleman who had been carefully studied and well treated by many gastroenterologists because of a persistent sense of fullness and pressure in the epigastrium accompanied by a severe burning sensation. When seen he was under the care of a neurologist who clearly recognized the psychogenic basis for his symptoms. After various forms of treatment had proved of little avail, he was finally referred to the Department of Physical Medicine, too often used as a last resort in the management of cases of this type. The local application of infra red, diathermy, the use of massage, and spinal manipulation all failed to bring desired results. After being assured that a new and severe form of treatment would bring him relief, he was placed in front of an imposing static machine. Static electricity was applied during which he was able to hear the noise and watch the jumping sparks. The next morning the patient volunteered the information that for the first time in months he had been free of burning, had had a good night, slept soundly, and was free of his discomfort. Since that time static electricity has continued to bring about good results.

Recently we have had under observation an intelligent but rather neurotic, well-to-do, middle-aged woman. For years she had been

suffering from severe abdominal distress brought about by spasms of the colon and of the pylorus. As a result of these painful spasms she was unable to eat or sleep; she had frequent attacks of vomiting. Through her thin, abdominal wall the spastic gut could readily be palpated. She had been studied with extreme care by a number of excellent gastroenterologists. She had been subjected, as is frequently the case with such patients, to several pelvic and abdominal operations. Again, in desperation she was turned over by her medical advisers to the Department of Physical Medicine. The patient herself was convinced that she could not be benefited by drugs and that proper manipulation of her abdomen was her only hope. Under the skillful, patient, gentle manipulations of a well trained physical therapist who has had a wide and varied experience in the management of psychoneurotics, her spasms were gradually brought under control, her bowel relaxed, bowel movements became normal, appetite returned, and in the course of a number of weeks she was able to leave the hospital. For the time being at least, she is symptomatically improved.

From the foregoing it is not intended to imply that the chief value of physical medicine is dependent upon good psychotherapy. The point to be emphasized is that in many patients it is often difficult to decide whether subjective improvement is to be attributed to psychotherapy more than to the physical forms of treatment employed. In many instances, as for example in the last case cited, a happy combination of both psychotherapy and physiotherapy was responsible for the results obtained. The psychic factor must be recognized as an important variable which makes it difficult to control clinical research carried out upon human beings. In the past this has sometimes been overlooked. There is no impropriety in knowingly employing physical forms of treatment in order to obtain a definite psychologic effect. Under properly regulated conditions it becomes an exceedingly appropriate and valuable thera-

peutic approach. Criticism can only arise when the psychologic element is disregarded in appraising the value of any form of physical therapy.

DISEASES IN WHICH PHYSICAL MEDICINE IS OF VALUE

There is scarcely a condition or disease that at some time, somewhere has not been subjected to some type of physical medicine. In the time at our disposal it is clearly impossible to attempt consideration of all the possible uses of physical therapy. It would seem more profitable to focus attention upon those conditions for which patients most often seek relief through physical methods of treatment. In order to ascertain the disorders that fall into this category the experience of the Department of Physical Medicine of a large general hospital, in this case the hospital of the University of Pennsylvania, over a period of the last 9 months has been analyzed. The material that is encountered in a large, general, urban hospital coincides more nearly with that found in general practice than is the case when the experience of certain special hospitals is considered. The picture presented by a great military hospital such as the Walter Reed or a hospital connected with hazardous industries in which the bulk of the patients referred for physiotherapy have sustained some type of trauma is very different from that seen in the ordinary civilian hospital. The same is true of hospitals limited to the care of psychiatric patients, to children, or to orthopedic patients.

In the Department of Physical Medicine of the University of Pennsylvania between June 1, 1944 and April 1, 1945, 10,497 treatments were given. During this time 906 new patients were admitted to the Department for examination and treatment. An analysis of this group of new patients shows that a little over 16 per cent were suffering from chronic arthritis or some allied rheumatoid condition. The majority of these cases could be grouped under degenerative joint disease, rheumatoid arthritis, and in a few

instances gouty arthritis. The next largest group, a little over 14 per cent, were referred with that common but most unsatisfactory diagnosis, low back pain. Among these were included 9 instances of herniation of intervertebral discs. In the majority, however, the cause of backache was found in faulty posture, lumbosacral and sacroiliac strain, and rheumatoid arthritis of the spine. If the cases of fibrositis or fibromyositis, which represented about 9 per cent, are included in the 2 foregoing groups, approximately 40 per cent of the individuals seen in the Department of Physical Medicine during the past three quarters of the year were suffering from some manifestation of arthritis or allied rheumatoid disorders. Fractures or disabilities immediately resulting therefrom accounted for $12\frac{1}{2}$ per cent of the new patients. A varied assortment of orthopedic conditions accounted for a little over 12 per cent. Peripheral vascular disease, for the most part varying degrees of arterial occlusion, represented just over 6 per cent; neurologic cases made up 8 per cent. This number was about equally divided between functional nervous disorders and organic lesions of central origin; by far the greatest number of the latter were hemiplegias. Peripheral neuritis of one cause or another, including 14 instances of Bell's palsy, accounted for 5 per cent. So-called subdeltoid bursitis was observed in 41 cases; 30 patients were suffering from sprains; there were 11 instances of dislocation, 9 cases of scleroderma, and only 11 patients with chronic poliomyelitis. The remaining cases represented miscellaneous diagnoses and included such conditions as metastatic carcinoma, leukemia, chronic ulcers, angina pectoris, hypertension, and chronic sinusitis. The impression was gained that many of the cases in the latter group were referred for physical therapy as a last resort or with the hope that they might obtain a psychologic benefit.

This survey of new patients shows that the majority were referred from the arthritic clinic,

the orthopedic and neurologic services, and the fracture service. It is significant that as yet a number of the active hospital services including general medicine apparently do not feel any great need for physical therapy as an adjunct to treatment.

The foregoing analysis confirms what has long been recognized, namely, that in the treatment of the arthritides and allied rheumatoid conditions the practice of physical medicine plays an important and indispensable role. The discussion of the various procedures in physical therapy that may prove of value in the management of the arthritic presents an exceptionally good opportunity to consider all of the more important clinical aspects of physical medicine.

PHYSICAL THERAPY OF ARTHRITIS AND ALLIED CONDITIONS

Comroe³ has recently emphasized that physical therapy alone will not cure most cases of arthritis. Nevertheless, it is generally agreed that physical therapy is one of the most useful adjuncts to the treatment of most arthritic patients, especially those in whom the condition has reached a subacute or chronic stage. When it is realized that in this country more people are suffering from arthritis or some other rheumatoid manifestation than the sum of all the individuals who are affected by cancer, tuberculosis, diabetes and heart disease, it is evident that in this group of diseases alone physical therapy enjoys an immense field of clinical usefulness. To be effective in arthritis, physical forms of treatment should not be carried out casually and at irregular intervals. A carefully worked out routine should be followed. Whenever possible, treatments should be given daily, in the home as well as in the office or hospital.

One of the most useful forms of physical therapy in the management of the arthritides is massage. Pemberton⁴ has maintained that one of the most valuable measures in the treatment of arthritis and one of the oldest therapeutic agents in the history of medicine is massage

with its associated variations. The beneficial effects of massage are most apparent in chronic conditions. Its value depends primarily upon its prolonged and systematic use. It is not a therapeutic procedure to be employed in the acute stage of joint disease when it may be productive of more harm than good. It certainly has no place in the management of acute rheumatic fever. Although massage is one of the oldest and best known forms of mechanotherapy, it is imperfectly understood and often improperly used by many physicians. As is the case with every effective form of therapy which, when properly prescribed and carried out, is capable of doing good, massage has its definite limitations and contraindications. Physicians should be sufficiently familiar with the various forms of massage, the special indications for their use, and the physiologic changes which they bring about to be able to intelligently prescribe the details of such treatment. Menell⁵ made a statement that should be recalled: "When a medical man orders massage, he should not try to hand over his responsibility to the masseuse. He should consider the prescription of massage treatment in the same light as he would consider that of a potent drug and watch its effects no less closely, varying the dose and the nature of the dose from time to time according to the indications."

The physiologic effects of massage have been clearly set forth in an admirable article by Scull.⁶ According to this observer, reduced to its simplest terms massage involves the application of the stimulus of pressure to tissues. This brings about the following effects: (1) mechanical displacement of fluids, (2) the removal of toxic or foreign material from focal lesions, (3) neurovascular adjustments, secondary to sensory reflex nervous responses that result from various pressures of cutaneous and muscular structures, (4) neuromuscular effects, either the direct result of muscular stimulation or secondary to the neurovascular responses, (5) general metabolic and biochemical effects, and (6) circulatory

effects characterized by peripheral vasodilatation associated with an increase in the rate of peripheral blood flow. These effects may be modified according to the kind of massage employed. It is, therefore, essential that those ordering massage should be familiar with the various technics in order that the dosage may be qualitatively and quantitatively regulated to meet the desired indications. The technics commonly employed may be divided into light stroking, often referred to as effleurage, deep stroking, kneading or compressive massage, and percussive massage. Others types of massage have been employed from time to time but those above referred to are the most generally useful. Several misconceptions in regard to the effect of massage should be dispelled. There is no clinical or experimental data to show that heavy massage is capable of eliminating local fat deposits. Nor is there evidence to substantiate the belief that massage is capable of increasing muscular strength, which can only be accomplished by active exercise.

In chronic arthritis properly applied massage is capable of doing good according to Pemberton⁴ in four ways: 1. It helps to prevent or delay atrophy of muscles and aids in the restoration of muscle tissue when atrophy has already occurred. 2. It improves the general and local metabolism. 3. It increases the amount of circulating blood to certain tissues and facilitates the return to the circulation of many corpuscular elements tucked away in inactive regions. 4. It lessens local edema by mechanically bringing about the effects normally exercised by muscles in aiding the heart to empty the venous circulation.

Clinical experience confirms the belief that this form of mechanical treatment induces definite physiologic changes. Like all forms of effective therapy satisfactory results cannot be expected if it is administered under a blanket prescription. It should be carried out by someone skilled in the technic, familiar with the anatomy and physiology of the part involved.

and trained to follow explicitly directions laid down by a physician as to severity, duration and frequency. The best results are obtained from massage when it is used as part of a well integrated therapeutic regimen and not as an isolated procedure. It should also be emphasized that it can never take the place of exercise. Although it occupies a definite place as an adjunct in the treatment of chronic arthritides, as soon as the clinical indications warrant, massage must be supplemented or replaced by passive and, as soon as possible, active exercise.

It has long been recognized that the effect of massage and other manipulative procedures is enhanced if associated with the use of heat. The local and systemic use of various forms of external heat constitutes another valuable therapeutic aid in the management of the arthritides.

The local application of heat is a time-honored and well recognized procedure. Heat may be applied by three methods: (1) conduction, or direct contact from a heated object, such as the traditional hot brick, hot water bag, or the electric pad, (2) convection, as when heat is applied to the surface of the body from some external source, such as lamps, coils, reflectors, etc., and (3) conversion, as when heat is developed in the tissues of the body by reason of the resistance which they offer to the passage of a high frequency current (diathermy).

The physiologic effects of local heat are the same regardless of the type of heat used. They consist in the dilatation of blood vessels, an increased rate of blood flow accompanied by an increased metabolic activity, alkalosis, and probably an increase of local tissue immunity by accelerated phagocytosis. The only difference to be noted is some variation in penetrating ability dependent upon the way heat is applied. Conductive heat penetrates but little below the surface of the body; convective heat penetrates the skin layers and is said to penetrate to some extent into the subcutaneous tissue fat. However, there is reason to believe that the dull glow of certain coils is largely absorbed by the super-

ficial layers of the skin. On the other hand, conversive heat produces the greatest amount of penetration.

Innumerable methods for the local application of heat have been devised. Each has had its champions, and from time to time considerable discussion has arisen as to their relative merits. To attempt a detailed discussion of these various forms of apparatus and an evaluation of the claims made for them would be out of place at this time. In the selection of the form of heat to be used one has to be governed by the facilities available and the accessibility of the part to be treated, since the local effects of heat are the same regardless of the type used. It is worth bearing in mind that such an expert in physical medicine as William Bierman⁷ regards the economical and lowly carbon filament lamp as an instrument that compares favorably in usefulness with many of the more expensive and elaborate forms of apparatus. Recently enthusiastic and at times exaggerated claims have been made for the value of diathermy in the treatment of the various types of arthritis. As Comroe³ points out, the beneficial effects obtained from diathermy, whether short or long wave be used, is not due to any specific biologic or bactericidal action. Its effect in arthritis is similar to that obtained through the application of any other form of heat. It has been our observation, however, that when a single joint is to be treated or when it is desirable to localize the heat to a limited area, this is accomplished better by the more concentrated heat of long-wave diathermy, which gives better results than the more diffuse form of heating. Mention should also be made of the paraffin bath or pack as an effective method when the prolonged application of heat is desired.

Although less generally applicable than local heat, the systemic use of heat has been employed from time to time in the management of the arthritides. The immediate effect of heat is to raise the temperature of the body tissues. The degree to which the temperature rises and the

duration of this rise depend upon the amount of heat that is used, the extent of the surface exposed, and the length of time of application. Sweating is a phenomenon that invariably accompanies the general application of heat. The systemic use of heat is not suitable for all patients. It finds its usefulness in those in whom there is multiple joint involvement. It is contraindicated in those who are underweight, debilitated, and old.

The usual methods for the systemic application of heat are hot baths of various kinds, hot packs and the several types of electrically or steam-heated cabinets. Electric cabinets in which patients sit in the upright position are undesirable for a number of reasons. If cabinets are to be used they should be constructed so that the patient can be recumbent while being subjected to heat. The more severe, prolonged forms of fever therapy are as a rule undesirable for the chronic arthritic patient. By the use of electric light cabinets and hot baths mild degrees of fever, 1 or 2 degrees, may be readily induced and maintained for periods of half an hour to an hour, often with excellent results. During the time that patients are being subjected to general heat they should be constantly and carefully observed. Excessive sweating for too long a time should be avoided. The effectiveness of systemic heat in arthritis is greatly increased if the sweating process is followed by properly regulated contrast baths and rest.

In the management of arthritis hydrotherapy is closely allied to the use of heat. The two methods of treatment are frequently combined. As a medium for the application of external stimuli, water has the advantage of being an excellent conductor of heat. It enables thermal stimuli to be more intense and less variable. Furthermore, immersion in water overcomes to a considerable extent the force of gravity, it relieves muscular spasm, stimulates the cutaneous circulation and produces more often than not an excellent psychologic effect upon the patient. The combined effect of heat and water are taken

advantage of in such well known forms of hydrotherapy as hot compresses, general hot baths, various types of wet packs, contrast baths, sprays, douches and whirlpool baths. The latter are of distinct value in the treatment of certain forms of arthritis involving the extremities. Whirlpool baths consist of water that is kept whirling and aerated by mechanical agitation. The temperature of these baths is maintained between 100 and 110°F. Their advantage is that a gentle, continuous massage is added to the effects of the heat.

Personal experience leads to the conclusion that the most effective form of hydrotherapy in arthritis is the underwater treatment. This requires the use of pools or tanks, of which the Ille-Hubbard tank is an excellent example, so designed that when the entire body is immersed, complete range of motion in all the joints is possible. The great advantage of underwater treatment is the ability of water, by reason of its buoyancy, to overcome the force of gravity. This is based upon the law of physics long ago laid down by Archimedes that a body submerged in water will lose as much weight as the weight of the water displaced. Since the specific gravity of water is about the same as that of the body, the sustaining power of the water almost completely carries the weight of the body. As a result it is possible for weakened muscles and diseased joints to perform motions under water with little or no discomfort that would be virtually impossible out of water where the force of gravity can operate. Passive motion and muscle reëducation are carried out much more effectively in such a bath.

When the patient enters the tank the water is usually 96° to 98°F. It may be gradually increased up to 102°F. in the course of a few minutes. If the general massage effect of a bubble bath is desired, the water may be agitated at varying degrees of intensity by the use of small turbines designed for that purpose. Such baths are given from 10 to 20 minutes on alternate days. As a result of underwater

exercise pain is relieved, spastic muscles are relaxed, atrophied muscles are actually strengthened, and an increase in the range of joint motion is obtained. It may be added that the psychologic effect of increased motion obtained by underwater exercises is most encouraging.

Exercise is another important form of physical therapy that is a valuable adjunct in the treatment of the arthritic. Although the underwater exercise just referred to should be used whenever possible in the early cases of arthritis, there are other types of passive and active exercise that are effective when carried out systematically under proper supervision. As soon as the acute inflammation has subsided muscle setting exercises should begin. These consist of contracting muscles without causing joint movement. These should be followed later by assisted active exercises, unassisted exercise, exercise without weight bearing, and finally weight-bearing exercises.

Posture, body mechanics, therapeutic exercises, muscle reëducation, and the correction of deformity by exercise are aspects of physical medicine which are constantly claiming greater interest. It is a field of therapeutics which deserves far greater attention from the medical profession than it has received hitherto. This sphere of physical medicine is applicable not only to arthritics but to many other conditions.

The problem of exercise in arthritis is a broad one. In prescribing it certain basic principles should be kept in mind. These have been well set forth by Comroe³ as follows: "At least one or two gentle, painless movements of the affected joints must be performed daily even in the acute stage of the disease so that dense adhesions are not allowed to form. In acute cases relaxed motion is advisable. Definite exercises should not be begun until a joint is without pain while at rest. As the patient improves, the amount and usually the type of exercise are modified and increased. Attention should be given to underwater exercises and sling suspension exercises. The Hubbard tank may be used for all

exercises in the early arthritic cases; a simple tank may be made for home use. Active movements (by the patient himself) are always to be preferred to passive movements (by an assistant). Never exercise a patient to the point of pain or fatigue. Any motion which is attended or followed within 24 hours by an increase of pain, swelling or stiffness in the joints has been excessive; this must be reduced or modified. Proper exercises should cause no pain during their performance. When the acute stage of the disease passes, and the patient moves the affected joints slightly, active therapeutic exercise is begun. Never force a joint; this may result in a flare-up of a smoldering arthritic process."

As in many other conditions, so also in arthritis, heliotherapy, which is a form of ultraviolet irradiation, has its champions. There is no convincing evidence that ultraviolet light has any specific effect upon joint conditions. In spite of the exaggerated claims, the most that can be said for ultraviolet irradiation is that within certain ranges of wave length it is capable of bringing about chemical changes in the living animal that activate vitamin D, which in turn influences the metabolism of calcium and phosphorus. The antirachitic substance thus produced is capable of favorably influencing rickets as well as tetany and other conditions that depend on a calcium deficiency. In the arthritic patients who are undernourished and are deprived of an adequate amount of sunshine, ultraviolet light is undoubtedly of value as an adjunct capable of raising the blood count and improving the general nutrition.

All that has been said of the various forms of physical therapy in relation to arthritis is equally applicable to the various nonarticular manifestations of the rheumatoid state. Conspicuous in this group are those ill-defined conditions that have been referred to as fibromyositis or fibrositis. In spite of the fact that these conditions account for a considerable amount of the work that passes through any Department

of Physical Medicine their etiology, pathology, and clinical course are still none too clear. Cooksey⁹ holds that the essential lesion in fibrositis is a low-grade inflammatory reaction in the dense connective tissue. This results in the production of the much discussed "nodules" due mainly to local areas of transudate under tension in the inelastic structure. The hard nodules observed in chronic cases are due to areas of fibrosis, the result of repeated attacks. The chief indication for treatment of fibrositis is to relieve the pain, thereby relieving the associated muscle spasm, and to promote the absorption of the inflammatory exudate and improve the local circulation. In addition to the use of analgesics this is best accomplished by physical therapy in the form of various local applications of heat combined with massage. The form of massage known as finger-tip friction is particularly efficacious in this condition. It is not uncommon to hear physiotherapists and others refer to breaking up or dissipating fibrotic nodules. What actually occurs is that by finger-tip pressure the inflammatory edema is pressed out of the connective tissue and the absorption of the exudate is promoted.

The majority of cases of low-back pain, so-called sacroiliac strain, fall within the category of arthritic and rheumatoid conditions. Either as the main factor in their treatment or as an important adjunct to other forms of treatment, including surgery, physical therapy plays an important role. The forms of physical therapy most useful in these conditions are again the local application of heat in the form of baking, hot compresses, infra red radiation, hot baths, and at times diathermy associated with suitable massage, followed later by suitable corrective exercises.

Since the various forms of arthritis and associated conditions represent nearly 50 per cent of the patients seen under ordinary circumstances in the Department of Physical Medicine of a general hospital, it has seemed appropriate in discussing physical medicine from a

clinical standpoint to dwell upon this group of diseases in some detail and to describe various forms of physical therapy in connection with them, particularly since all the more usual technics of physical medicine find an application in the rheumatoid disorders. From this, however, it must not be inferred that the practice of physical medicine is not applicable with equally good reason to many other disorders.

PHYSICAL THERAPY OF FRACTURES

Physical therapy enjoys a wide field of usefulness as an adjunct in the treatment of fractures, dislocations and sprains. Recent years have seen considerable progress in the management of fractures, which has included a better understanding and increased use of physical therapy in their aftertreatment. There is a definite tendency now to employ manipulation and massage earlier in the treatment of fractures than formerly. As pointed out above, massage does not have the ability to build up or to strengthen muscles. In the present-day treatment of fractures, therefore, it should play a subsidiary role. At best massage is only capable of relaxing muscle spasm, improving the circulation of a limb, reducing edema, and aiding in the resolution of indurations about a joint or at the site of fracture. As pointed out by E. J. Crisp of Guy's Hospital¹⁰ in fractures that have been correctly handled, massage is seldom necessary and may be harmful: "The only short cut to rapid and complete recovery of function is by voluntary muscle contraction, and this forms the whole basis of modern rehabilitation."

Suitable physiotherapy should be instituted as soon as possible after a fracture has been reduced. Early in the treatment muscle-setting exercises that act upon the joints that are properly immobilized should be started. At the same time active movements of the fingers and toes and of joints which are not immobilized must be encouraged. Such procedures retain muscle tone, lessen the possibility of stiff joints, and above all teach patients to help themselves.

Suitable occupational therapy should be begun as soon as possible after reduction and immobilization. In no group of diseases is the necessity for guided and carefully regulated exercise more essential than in the treatment of fractures. Those who are familiar with this subject advocate the use of assisted movements rather than passive movements which are capable of doing harm unless they are carried out with extreme care and precision. From assisted movements patients graduate to active exercise, at times supplemented by resisted exercises. The more violent, forced movements are seldom necessary if the previous treatment of the fracture has been correct. In some instances the aftertreatment of fractures is helped by the local application of heat, and in selected cases excellent results are obtained by the use of underwater exercises. Today the keynote of the rehabilitation of the patient suffering from fracture or allied conditions such as dislocations and sprains is active exercise whereby the period of convalescence is reduced and self-reliance increased.

PHYSICAL THERAPY OF PERIPHERAL VASCULAR DISEASES

Physical medicine finds a definite field of clinical usefulness in peripheral vascular disease. These patients may be divided into two main groups: those in whom vascular obstruction is due to spasm with little or no organic disease of the blood vessels and those in whom the blood vessels show actual organic changes of the vessel walls associated with true occlusion. In the former, vasodilatation may be brought about by the use of diathermy or other forms of local heat, particularly keeping the limb warm under a cradle heated by electric light bulbs. In the latter group, whose peripheral blood vessels have for the most part lost their elasticity, the use of moderate heat has to be supplemented by other measures. The device which has proved most effective in our hands has been the suction pressure boot. A number of models are now

available, all constructed along the same principles as the boot originally described by Landis and Gibbon,¹¹ in which alternating positive and negative pressures can be applied to a limb encased in an air-tight glass boot. The air within the boot is alternately compressed and evacuated by means of a motor. As a rule, the pressures in the boot are alternated so that for 25 seconds there is a negative pressure ranging from 80 to 120 mm. of mercury and for 4 seconds a positive pressure is maintained of from 20 to 80 mm. of mercury. By means of such a positive and negative pressure device the peripheral capillaries and venous reservoirs are alternately filled and emptied with the result that the rate of blood flow through the extremity is increased. Although there is some divergence of opinion, there seems to be every reason to believe that such a treatment carried out over a considerable period of time in many cases aids in establishing a better collateral circulation.

Similar results may be obtained but less satisfactorily by the use of special exercises, notably those described by Buerger. More recently Sanders has devised a motorized, oscillating bed¹² for the treatment of cardiac and vascular disease. The bed oscillates slowly, raising and lowering the head to an arc of about 60°.

PHYSICAL THERAPY OF NEUROLOGIC CONDITIONS

Well over one half of the patients that have been referred by the Neurological Department to the Department of Physical Medicine suffer from functional disorders that could be classified as psychoneuroses. In this group the psychotherapeutic value of physical medicine is most evident. It is also true that many of the procedures employed improved their general condition and muscular tone. These patients responded best to various forms of hydrotherapy, especially warm baths, bubble baths, contrast douches, alternating with general massage, and, when indicated, corrective exercises

designed to improve muscle tone, posture and breathing.

The organic neurologic cases represented for the most part individuals who had suffered cerebral accidents or trauma with resulting partial or complete monoplegias or hemiplegias. The result of physical therapy in this group depends entirely upon the extent of the destructive lesion. In those in whom there is some return of voluntary motion, much can be accomplished by proper muscle reëducation. Contractures and deformities may be overcome by the use of heat with massage and passive motion. Various forms of electric stimulation may aid in maintaining the muscular tone and certainly are a help in improving the morale of the patient, but there is no evidence to indicate that any such procedure is capable of restoring function where nerve-cell destruction exists.

A considerable number of individuals complaining of various types of neuritis including Bell's palsy have been under our observation from time to time. After the acute manifestations have subsided many of these patients seem to improve under the judicious use of mild electric stimulation in conjunction with heat in the form of diathermy or infra red and gentle massage. Whatever form or combination of treatment is used, care must be taken to do nothing that will bring on increased pain or muscle spasms. Contrary to most contemporary opinions, in a certain number of cases of neuritis distinct relief of pain has been obtained by the proper and careful use of static electricity.

The hope for improvement in cerebral palsies (Little's disease) lies in physical medicine. The procedure is tedious and difficult and consists of a complex routine training program designed to establish normal coördinated movement. This can best be done in clinics and training schools designed for the purpose and requires physical therapists especially trained in the technic supervised by physicians familiar with the procedures.

There are few diseases in the treatment of

which physical medicine plays such an important part as poliomyelitis. This fact is now not only well known to the medical profession but is equally well understood by the laity, thanks to the widespread discussion and publicity that has been given Sister Kenny. It would be inopportune and inappropriate here to enter into a discussion of the controversial subject of the Kenny concept and treatment in poliomyelitis. Suffice it to point out that Sister Kenny has not invented any new treatment. She has merely, knowingly or unknowingly, combined forms of treatment long known and well recognized into a rigid routine for the management of poliomyelitis. Sister Kenny is deserving of credit for having aroused renewed interest in this dramatic affliction. This has stimulated research and has definitely improved the management of these patients, particularly in the early stages of their disease. The modern treatment of poliomyelitis exemplifies well the value of systematically used hot packs for the relief of muscle spasm followed at the appropriate time by prolonged, painstaking muscle reëducation. In a disease such as poliomyelitis that is subject to wide variations in its severity and clinical manifestations and which is capable of spontaneous recovery, it is admittedly difficult to accurately evaluate any special form of therapy.

In the foregoing remarks it has obviously been impossible to deal with all the procedures embraced under physical medicine or to discuss all of the conditions in which physical medicine has a definite clinical application. Procedures in which personal experience is totally inadequate have been deliberately omitted, as, for example, the use of severe fever therapy, electric shock therapy, surgical diathermy, iontophoresis, radiotherapy, and refrigeration, all of which properly fall within the domain of physical medicine. No attempt has been made to discuss in detail the various forms of treatment applicable to the numerous orthopedic conditions and miscellaneous diseases that from time

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NEW ASPECTS OF VENEREAL DISEASE CONTROL*

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THE pathology of syphilis and gonorrhea has changed very little through the years, but the control of the venereal diseases has undergone and is undergoing great changes.

The attention of the world today is focused on international affairs. Much of the attention of those concerned with venereal disease control also must be focused on international considerations. Already the great movement of masses of displaced populations in Europe, as the Allied armies free thousands of war prisoners and conscripted male and female workers, has created new problems of public health in liberated and occupied territories. The venereal disease rates in many parts of Europe are known to have increased sharply during the war. The movement of millions of men in armies and millions of repatriated civilians from one part of the continent to another is accelerating the dispersion of venereal disease infections. In so far as members of the Armed Forces of the United States are concerned, it is assured that virtually no infectious venereal disease will be brought back to the civilian population by demobilized soldiers and sailors, for both the Army and the Navy already are conducting rigid control programs wherein men with venereal disease are treated to non-infectiousness before separation from the services. The medical records of servicemen so treated will be forwarded to appropriate state health officers for follow-up. Comparable systematic control among migrating civilian populations abroad, however, is impossible. Consequently, when the war is over and the expected great flow of commerce and traffic from nation to nation gets under way, the inter-

national aspects of venereal disease control will assume large proportions, for no longer can the venereal diseases be considered to be isolated or insulated in sections or areas. A beginning already has been made in the direction of international control. There is now in operation a system whereby sources of infection, as reported by members of our Armed Forces abroad, can be traced and brought to treatment. The contact reports are forwarded, through the State Department, the Army, or the Navy, to health authorities of the countries, and in many instances the health authorities of these countries have located and brought to treatment the infected persons sought. Further, more highly systematized international venereal disease control work is an important postwar health goal.

Another important new aspect of venereal disease control is the increasing emphasis on realistic public education and community action. More of the efforts of venereal disease control officers and educators are now being directed toward the people who most need information, frequenters of beer halls, taverns, juke joints, and similar places where it is known that encounters leading to venereal disease infection most frequently occur. It remains necessary, of course, to inform parent-teacher associations, civic clubs, and other community groups regarding the venereal disease problem, but educational activities should not be directed to these groups alone.

It has been demonstrated, during the wartime emergency, that community action and law enforcement can reduce the spread of venereal disease by reducing prostitution. In more than 650 communities that formerly were plagued with prostitution, organized vice no longer

* Read before the Society, March 14, 1945.

exists, and thousands of cases that might otherwise be spread by the former inmates of closed houses of prostitution are being averted.

Repression of prostitution, however, is not preventing the many thousands of new venereal disease infections being spread by women and girls—a startlingly large proportion of whom are in their early teens—who give, rather than sell, their sexual companionship. The problem of the casual sexual association in which no fee is involved has been labeled “promiscuity,” and it presents the largest sociologic problem in venereal disease control. Promiscuity, however, cannot be controlled readily by law enforcement agencies, health departments, or indignation meetings. It represents on the one hand a transient, abnormal form of behavior, or, on the other hand, the habitual behavior of the promiscuous individual. There is good evidence that most promiscuous sexual behavior has its roots in the social and emotional adjustment of the individual, and that the trend of this adjustment is determined in the church, the school, and especially the home. Venereal diseases are a symptom, not the principal end product, of promiscuity and of the maladjustments which accompany or precede promiscuity.

Mass emotional and psychologic unrest, as well as individual maladjustment, however, are contributing to the dissemination of venereal disease, and it is to be expected that this unrest, born of the war, will reach a peak during the postwar readjustment period.

During the war, while many influences have tended to increase the spread of venereal disease, medical science has made important counter advances against syphilis and gonorrhea. These medical advances probably should be credited with averting what otherwise could easily have been a far graver situation than now exists. The incidence of gonorrhea is now higher than ever before, compared with the incidence of syphilis. The role that the sulfonamides have played in first checking gonorrhea, and then, possibly, contributing indirectly to its

spread, is the subject of discussion and debate among epidemiologists. When the sulfonamides first were introduced in the treatment of gonorrhea they were very effective, and cured 80 to 90 per cent of all gonorrheal infections in the treatment of which they were employed. Subsequently, however, the proportion of cures decreased, until at present the sulfonamides cure only about 20 per cent of gonorrheal infections. Whether the gonorrhea organisms have become sulfonamide-resistant, or whether there were originally sulfonamide-resistant strains and sulfonamide-susceptible strains, and as a result of treatment it is chiefly the sulfonamide-resistant strains that now remain, is less important epidemiologically than the fact that ultimately the sulfonamide drugs produced many asymptomatic gonorrhea carriers. Nevertheless, some physicians believe that the early success of the sulfonamides so greatly retarded the spread of gonorrhea during a wartime period when the exposure rate was high that the subsequent ascendancy of sulfonamide-resistant strains has not offset the original gains. However that may be, the timely advent of penicillin averted possible disaster in so far as gonorrhea is concerned, and penicillin promises also to be very useful in the control of syphilis. Never before in the history of medicine have we had one drug that seems to be effective in two diseases so dissimilar as to pathology and so closely related as to source and spread. More than 5,000 cases of gonorrhea have been treated with penicillin without a failure. Physicians in private practice now are curing gonorrhea in their own offices, in 4 hours, by administering 200,000 units of penicillin in 3 intramuscular injections 2 hours apart. Soon it seems likely that they will be able to cure 94 per cent of gonorrhea cases with a single injection of a mixture containing penicillin, and the remaining 6 per cent can be cured by retreatment.

The simplicity, the promptness, and the dependability of penicillin therapy for gonorrhea should arouse the active interest of every physi-

cian in finding and treating gonorrhea. The increased participation of private physicians in the treatment of gonorrhea with penicillin should have a favorable effect on syphilis case-finding, for something like 10 to 20 per cent of gonorrhea patients are infected with syphilis also.

Penicillin apparently is of value in the treatment of about 90 per cent of cases of early syphilis. It will take years to evaluate fully the efficacy of penicillin in the treatment of syphilis, but at present it appears that the drug is safe, non-toxic, and "cures" syphilis to about the same extent that other drugs used in the past have cured the disease. Intensive arsenotherapy in special hospitals, and the standard 70-week course of arsenic and bismuth injections, administered by the private physician or in clinics, however, undoubtedly will be employed in the treatment of the majority of syphilis patients for some time to come.

Despite advances in therapy, syphilis and gonorrhea are a long way from satisfactory

control because methods of discovering infected persons have not kept pace with either the treatment or the spread of the diseases. It is in the direction of case-finding that the next great advance in venereal disease control must be made. Productivity of case-finding through voluntary seeking of diagnosis, through mass blood testing, and through investigation of sexual contacts reported by infected persons must be stepped up. The physician in private practice can speed this advance by routinely examining more patients for evidence of venereal disease infections, and by more persistent efforts to discover from whom and to whom known infections may have spread. The time element is critical in contact investigation, for obviously an individual with gonorrhea or with syphilis in an infectious stage and with diversified sexual contacts may be expected to spread the infection to four times as many persons in a month as he or she can spread it in a week.

THE FALLACY OF THE USE OF INTRAPERITONEAL SULFANILAMIDE IN THE TREATMENT OF PERFORATIVE APPENDICITIS

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AS REA¹ has pointed out, many reports on the use of sulfonamides in abdominal surgery have been misleading. Steinberg² has summarized the results of 9 groups of investigators, all of whom used sulfonamide compounds intraperitoneally in the treatment of appendiceal peritonitis. He found that the difference in mortality between the percentage of the control series wherever given and the treated series falls within the "standard error" due to chance. The results were not statistically significant. A resumé of a few early reports illustrates how the intraperitoneal use of sulfanilamide came to be generally accepted before an adequate basis had been established for the therapy. Welborn and Stubblefield³ reported 21 cases of acute perforative appendicitis treated with intraperitoneal sulfanilamide with 2 deaths, a mortality of 9.5 per cent. Anderson⁴ reported 17 cases of "advanced acute appendicitis" treated intraperitoneally with sulfathiazole with 1 death, a mortality of 5.8 per cent. Waugh, McCall and Herrell⁵ reported a series of 132 cases of perforative appendicitis all of whom received sulfanilamide or sulfathiazole intraperitoneally with a mortality of 3.8 per cent. Recently Aycock and Farris⁶ reported 82 cases of appendiceal peritonitis treated similarly with sulfanilamide with 4 deaths, giving a 4.8 per cent mortality. The series was divided according to the degree of peritoneal involvement. Twenty-six cases were classified as "early perforation," 27 were classified under "abscess formation," and 29 were

classified as "diffuse peritonitis." As would be expected there were no deaths in the early perforation group, 1 death in the abscess group and 3 deaths in the diffuse peritonitis group.

The perturbing element about these reports is that other groups working without sulfonamides can report equally low mortality rates for appendiceal peritonitis. For example, the Horsleys⁷ of Richmond in the period from January 1, 1931 to January 1, 1940 had 133 cases of peritonitis from appendicitis with 3 deaths (2.26 per cent).

TABLE 1

YEAR	NO. OF RUPTURED APPENDICES	NO. OF DEATHS	% MORTALITY
1940	44	2	4.5
1941	46	3	6.5
1942	73	4	5.4
1943	54	0	0.0
1944	47	2	4.2
1945	24	1	4.1
Total	288	12	Average 4.1

Table 1 shows the mortality following appendectomy for perforative appendicitis from the service of one of us (O. C. C.). A sulfonamide was not used. The period from 1940 through the early part of 1945 was selected for tabulation because that was the period of the most widespread intraperitoneal use of sulfanilamide.

Certain conclusions are obvious when a comparison is made of mortality figures from year to year as they are presented in the table. The mortality varies slightly from year to year among

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groups of patients receiving the same treatment. For example, if the results of 1943 could be considered alone a fairly sizable group without any mortality could be added to the confusion in the literature. Another possibility would be to add the figures for 1942 and 1943 so as to give 127 cases with 4 deaths, a mortality of 3.1 per cent. These rates could then be compared with the Waugh, McCall and Herrell⁵ series of 133 cases receiving intraperitoneal sulfanilamide with a 3.8 per cent mortality.

For the sake of completeness a brief outline of the treatment used for all the cases included in the table will be presented. As soon as the diagnosis of appendicitis is made immediate operation is undertaken utilizing a small muscle splitting incision over the site of the appendix. Suction is used to evacuate any quantity of peritoneal exudate and the appendix is always removed. The peritoneum is closed without drainage and the remainder of the wound is packed open with iodoform gauze. It is interesting to note that these details of treatment coincide closely with the program of therapy presented by Dr. John S. Horsley, Jr.⁷

During 1944 and the early part of 1945 the peritoneal fluid of 25 cases of peritonitis secondary to a ruptured appendix was cultured by the laboratory at Sibley Memorial Hospital. Twenty-two of these cultures were made at the time of the initial operation, and 3 were made at autopsy in cases of death from appendiceal peritonitis. Every case except 1 had the colon bacillus in the peritoneal exudate, and this case, curiously enough, had a pure culture of *Staphylococcus albus*. Twenty-two cases had *Escherichia coli* communis, and the other 2 had a hemolytic variety of *E. coli* in pure culture. Table 2 shows the incidence of other types of organisms found in combination with the colon bacillus.

It is interesting to note that clinically the sickest patients were those from whom was obtained the hemolytic type of *E. coli* or *Pseudomonas pyocyanea* in combination with

E. coli. Patients whose peritoneal exudate contained *Staphylococcus aureus* in combination with *E. coli* were not nearly so ill.

Other investigators working with patients suffering from peritonitis secondary to a perforated appendix have obtained similar results after cultures of the peritoneal exudates. Bower, Burns and Mengle⁸ reported a series of cultures obtained from 55 patients with gangrenous appendicitis and peritonitis. Their cultures demonstrated *B. coli* in 65.8 per cent of the total number of cases, *Streptococcus nonhemolyticus* in 14.6 per cent, *Streptococcus viridans* in 14.6 per cent, *Streptococcus hemolyticus* in 2.44

TABLE 2

ORGANISM	INCIDENCE ACCORDING TO NO. OF CASES	% OF TOTAL NO. OF CULTURES
<i>Staphylococcus aureus</i>	8	32
<i>Streptococcus hemolyticus</i>	2	8
<i>Streptococcus anhemolyticus</i>	3	12
<i>Streptococcus viridans</i>	2	8
<i>Pseudomonas pyocyanea</i>	3	12
<i>Bacillus subtilis</i>	2	8
<i>Staphylococcus albus</i>	1	4

per cent, and *Staphylococcus aureus* in 2.44 per cent. In addition to the aerobic bacteria they obtained *Clostridium welchii* in 60 per cent of their cases.

With the exception of the *Streptococcus hemolyticus* there is considerable divergence of opinion as to the effectiveness of sulfanilamide against the organisms listed in the table. In vitro sulfanilamide is not consistently bacteriostatic for *Escherichia coli*,^{9,10} and it is believed by the authors, at least, that sulfanilamide is of little use in vivo against the coliform organisms. Certainly sulfanilamide has failed clinically to aid much in the treatment of staphylococcal, *Streptococcus viridans* and *Pseudomonas pyocyanea* infections. Whether the presence of anaerobic bacteria in the peritoneum plays an important part in the end result of peritonitis is not known.¹¹ In any case sulfanilamide is less

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PUBLIC OPINION WILL DETERMINE MEDICINE'S FUTURE *

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THE following headlines recently noted are illustrative of many:

The Fight Breaks Out Again

Washington Trend Points to Federal Medicine Plan

Multi-Billion-Dollar Health Plan Proposed by Pepper Committee

Public Demand Health Plan, Says Sinai

Socialized Medicine Fears Groundless, Says Altmyer. Outlines Federal Plan

The Impact of Social Change on American Medicine.

Headline writers too frequently choose to imply that medical societies and associations are opposed to any change in the present system of practice. Although the story beneath the headline may defend the present methods or describe an attempt at a change offered by some group of physicians, nevertheless the headline will reflect doubt. The public, as we all have observed, too frequently limits its reading to headlines. Obviously our first step in securing the support of public opinion should be to achieve a change of heart in the headline writers.

Naturally we of the medical profession desire the public to be appreciative of the work we are doing and the position we are taking with regard to the changes in the system of medical practice proposed by those who argue that the present methods are antiquated. We are not absolutely opposed to modification, but we desire the progress to be by evolution and not by radical revolution.

The Council on Medical Service and Public Relations was set up by the American Medical Association for this purpose, and its platform sets

forth clearly its purpose, "to make available facts, data and medical opinion with respect to timely and adequate rendition of medical care to the American people; and to inform the constituent associations and component societies of proposed changes affecting medical care in the nation." It is in the Council's program to aid each component group to develop such plans as it may deem particularly adaptable to its constituency, recognizing that only in the most general terms can a national program be developed now. In developing its program it is collecting data and information from the state societies and associations as to what has been done, is being done, or is planned for the future. In conjunction with the Bureau of Legal Medicine and Legislation it is studying the bills that appear before the various state legislatures.

The Council thoroughly realizes that to make progress it must be supported by public opinion, and how easiest and best to secure that support is debatable. Should those persons or agencies which propose undesirable programs be treated as enemies of the profession and should steps be taken to discredit publicly the sponsors as well as their propositions? Does the public expect such heroic action on the part of the profession? Shall we assume that such moves as are undesirable to us are conceived to crush the medical profession rather than to advance the public welfare? Or shall the Council take a defensive position, ignoring the suggestions of change as being radical and therefore necessarily undesirable? Is the public satisfied with the profession's claims for excellence in the quality of medicine practiced as indicated in the low death rate and the extension of longevity?

* Read before the Society, May 2, 1945.

Some think that the profession can win public approval and support by challenging those who would change the status quo by proceeding with their plans; they argue that the American public would never submit to the regimentation that the system would necessitate.

Although each of these methods will achieve a measure of success, it may be asked whether any one of these or even all would finally dispose of the matter in a way that would command wide public support. In fact, it is no longer a hypothetical question; we know that these methods now being employed more or less extensively are not creating a sympathetic public spirit. The public seems to go grudgingly with us, somewhat provoked that they cannot wholeheartedly support us in the protection of the public welfare. Two brief excerpts from letters written by congressmen to physicians illustrate this situation. The sentiments expressed are commonly heard when the matter is discussed on "the hill."

"I am opposed to the governmental control of any profession, but I do not feel that the organized medical profession is attacking the problem in the proper way. We have a tremendous health problem in this country, . . . and unless the medical profession organizes and participates in the public health program in a way that will, if not immediately, at least gradually meet the health needs . . . , those who would socialize medicine will be in a position to force its passage."

"I am against government control of the practice of medicine but believe we are coming to some kind of control, or at least partial control. My idea will be to vote for some bill which will allow those in the medical profession to operate without regimentation and also allow citizens to select physicians of their choice. I know that sooner or later some sort of program will be adopted which will establish hospitals and medical care for those unable to pay for this service, but I do not want to vote for any measure that will lower the morale of the medical profession."

Whether a change in the present methods of

providing medical service to the public is necessary or not, the advocates of change have been so active and the rebuttal on the part of the physicians so ineffective that there is undoubtedly a predominance of public sentiment in favor of some change, although there is obviously no agreement upon what the change should be. One congressman said "the medical profession in some way must organize and participate in the public health program." We should "participate," not oppose, ignore, or challenge. Participation doesn't imply submission, but constructive consideration.

Supplying adequate medical service to a community is primarily the function of the local physicians; they are the specialists who have been scientifically trained for that purpose and the public so regards them. However, the thinking and intelligent public does not really expect them to do the work alone any more than it expects the lawyers to contribute their work gratis or the architects to build their public buildings with their own hands at their own expense. The public is accustomed to call on doctors in time of dire distress when there is not ample time to plan for meeting the costs of the emergency. Doctors must act immediately, and they do so regardless of remuneration. I hope that spirit will always prevail, but at least the architect and the merchant have taken steps to anticipate emergencies. They have taught the public to consider with them in ample time the cost of the services to be rendered. Until recently we have been inclined to look upon our coöperation in such protective programs as commercial, or we have feared that sharing might lead to unscientific interference or to some intangible loss of prestige, or "something." When the great economic depression first fell upon my community I happened to be holding a public position of responsibility that gave me a share in providing medical service to indigents. I was a personal friend of the welfare commissioner and realized the dilemma he found himself in. I was also a member of the county medical society's

committee on public health. I proposed that we, as a committee, invite the welfare commissioner to confer with us over the growing list of those who could not pay for their needed medical service. But for reasons I could never fathom the committee would not sit with him. He was left to work out a plan which the physicians criticized severely because they did thousands of dollars' worth of work for which they were not paid, while the public thought they were being paid and complained because the service was not more freely given.

When a defense industry decided to locate in a small rural community it was suggested that the physicians invite the mayor of the town and other public officials to a conference where the future problems of sanitation and medical service should be considered and plans to meet them discussed. The physicians procrastinated until the public officials had to meet the situation regarding sanitation unaided, and the physicians struggled alone with the problems of providing medical service.

Why should we physicians hesitate to consult with public officials in solving community problems? Why insist that there can be no other solution but the one we choose? Why try to force the public to accept a given plan without discussion? After all, the American people do not relish being told what they must do, but they will readily do it if they are given a share in determining whether it must be done. And regardless of the efforts to the contrary, the public generally triumphs in a large measure. A small group of advocates of state medicine have been striving for a generation to establish a plan but have been unable to sell their idea to the public, probably because all such plans threaten to a degree the independence of the individual. The rapid scientific advance of medicine with attending increase of cost and the advent of the economic depression have emphasized the factor of cost. The public realizes that it wants the best medical care and that it is necessarily expensive. The true American also wants to pay

for his services but is finding it increasingly difficult. Leaders in the profession are aware of these conditions and are wisely endeavoring to meet the situation with voluntary insurance plans. An opportunity presents itself for the profession to coöperate with the public in securing what it desires with medical direction.

But some physicians are loath to follow the leader. They characterize the public's interest in a change as leader-induced, and then those who are agreeable to modification cannot agree as to whether the plan should be predominantly "service" or "indemnity" in character. While we are discussing the merits and demerits of the several plans and making up our minds as to whether we can accept any plan, the public under other leaders slowly forges ahead. Some physicians would willingly pass the ball on to insurance companies, who, strangely enough, do not seem anxious to have it, and others are willing that the Blue Cross should take the lead.

Many polls have established that it is a fact that the public believes that all people cannot secure the proper medical service when needed, and these people are satisfied something should be done to correct this condition. Thus far it seems that the majority are not ready for the Government to take over, although the number that would have government aid by subsidy seems to be growing. Many congressmen have expressed themselves as opposed to regimentation of medicine by the Government, but desperately ask the physicians to propose some concrete substitution. They fear that if such substitute is not forthcoming the public will gradually adjust itself to some state medicine proposition. The endurance of the public is prodigious but can terminate. Governor Warren of California thought that point was reached this past winter, and leaders in some other states thought likewise.

Well, what are we going to do about it?

The popularity of hospital insurance is evidence that the public is insurance-minded, and, if the problem of providing a satisfactory

plan for medical service insurance is too difficult for the profession to solve, why not call into conference leaders of the public and not only "hear what they have to say about it" but ask them to assist in drafting a plan. To this conference, in my opinion, should be invited leading officials, government and lay, and especially representatives of industry, labor, education, the bar and the ministry. If such a group could agree upon a plan, it would be almost certain to have immediate public endorsement.

We all know that we physicians are individualists, having developed thus through education and practice; and therefore we are likely to be somewhat ineffective in developing a public relations program alone, but in such a conference as I have outlined we can be a great power if we have a public relations spirit in our hearts. We would be more efficient as public leaders if we endeavored to "see ourselves as others see us" and at the same time tried to have others see us as we see ourselves.

There is still time for the physicians to guide the public in planning for the future medical service program if we go about it in the right way. We should advance from the stage of discussing it only within the society behind closed doors to a place where we can discuss its ramifications with the purchasers or beneficiaries of the service. A willingness on our part to sit officially in such a conference, preferably arranged by us, would go a long way toward removing the stigma which now is attached to medical organizations. The following is an oft repeated declaration made by people when asked about the future of medicine, "Well, if all the doctors in the medical society looked upon that matter as my doctor does there would be no problem, but the medical organization is different."

What evidence have we that public opinion does prevail?

Bacterial origin of disease was scientifically established but not accepted by many of the leading physicians until public opinion, influenced by the demonstration that typhoid fever

was related to impure water and milk, demanded their purification. Venereal diseases, the seriousness of which was long known to the profession, were treated indifferently or neglected until public opinion demanded their early diagnosis and careful treatment. Immunization against diphtheria, long known to the profession, became a public necessity when public opinion was aroused.

Hospitals, still called "horsepitals" in some places, can hardly be built fast enough to meet the need since the public has outgrown its fear of them.

Public opinion seems inclined to interpret the phrase of the Preamble to the Constitution of the United States, "promote the general welfare," as meaning that the Government has an obligation to provide its citizens with medical care.

These positions of public opinion were not achieved automatically. They are the result of much effort on the part of some who were interested; witness the widespread interest in vitamins. Public opinion may not be widespread; for example, the sectional interest in quackery, osteopathy, chiropractic, Christian Science, is so established in some states that public opinion in their support interferes with the enforcement of the law.

From all of the evidence, it seems certain that public opinion will, in the future as in the past, have a determining influence on the character of the medical service it will have, and there is still time for the physicians to join with influential public agencies and groups in directing its course.

Recently I visited the annual meeting of the House of Delegates of a Midwestern state society. The chairman of the legislative committee reported that no adverse legislation had been enacted by the legislature; on the contrary, the enabling legislation which the society sought to aid in developing a voluntary plan had received unanimous support in both houses. I wondered how the physicians had secured such powerful public support and I was told that committees of

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President's Page

A PROMISE OF BETTER THINGS TO COME

The meeting for Sir Alexander Fleming, at which he told his story of the discovery of penicillin, was an outstanding event and unusually well attended. Our guest must have felt complimented by the rapt attention of his audience. The Chairman of the Program Committee, Dr. Oscar B. Hunter, who has a rare talent for planning meetings, is to be congratulated on securing Sir Alexander, and I think we can look forward with a lively sense of anticipation to what he and his Committee will present to the Society on meeting nights.

As the 17th ANNUAL SCIENTIFIC ASSEMBLY has been cancelled, we hope to make the programs throughout the year of such interest that the members will feel we have woven into our regular meetings much of the material that would have been presented at the ASSEMBLY. I hope that every member will keep Wednesday nights free so that the speakers will have the inspiration of a well filled auditorium.

In the last issue of MEDICAL ANNALS a roster of committees was published. Most of the men heading and serving on these committees have in the past done splendid work for the Society. With these experienced men I have tried to introduce many younger men so that they might become more familiar with the organization. I feel sure they will be increasingly interested and pleased to be a part of such a fine organization.

As months pass more medical officers are being released from the services. I would like at this time to welcome each member on his return to Washington. I hope these men will not only come to the Medical Society building, but will call on me personally for I would like to hear of their experiences and future plans. Colonel A. Clagett Gray and his Committee on Service Physicians are doing all they can to help these returning members. Office space is a real problem, but everything possible is being done to locate such space. Our Secretary, Theodore Wiprud, has kept in touch with many of the men, and if you have received his letters you have an idea of what has been going on in your absence. Most of you must have new ideas that will be helpful to us in conducting the affairs of the Society. It may be possible—in fact I think probable—that the war will end during my tenure of office. If so, we will be confronted by many problems. We need your help. If every member will give to the Society the same quality of thought and effort he gives to his own affairs, the net result should be unity, inspiration and accomplishment.

Wm. Earl Clark

Editorials

PROTEIN IN NUTRITION

A series of nine essays¹⁻⁹ on the significance of protein nutrition in health and disease have recently been published under the auspices of the Council on Foods and Nutrition of the A. M. A. These articles are especially timely in view of the national preoccupation with questions of diet, particularly questions relating to certain protein foods.

During digestion protein foods are first broken down into their constituent amino acids. After absorption a part of the amino acids is used for replacing and building body and plasma protein, and the remainder is deaminated by the liver, with the formation of carbohydrate and the production of non-protein nitrogenous waste substances. Protein in the body is continually undergoing changes; synthesis, transfer, resynthesis, and deamination for energy yield represent a constant state of chemical activity. The concept of great masses of inactive protein stores has been abandoned.

The supply of protein to the body depends on the dietary intake, normal digestion and absorption, proper utilization by the liver and other organs, and the rate of loss. The optimum daily protein intake in health is judged to be 1 gram per kilogram of body weight for the normal adult, 1.5 gram per kilogram during pregnancy and lactation, and 3 or 4 grams per kilogram during

infancy and early childhood with allowances only a little less during later childhood and adolescence. The need for protein is further increased in the course of many diseases and following operation, injury or burns. It has recently been emphasized that a high protein intake is especially important to the natural mechanisms of resistance to infection.

Recognition of protein deficiency depends on a painstaking appraisal of the dietary intake, a notably difficult task under most circumstances, an awareness of the conditions which increase the need for protein during health or disease, and the detection of hypoproteinemia. In our present state of knowledge the earliest clinical sign of hypoproteinemia is edema. Nevertheless, this is a relatively late manifestation, and a more useful indicator is the measurement of the concentration of the plasma protein. The normal range for the total protein is from 6 to 8 Gm. per 100 c.c., for albumin 4 to 5.5 Gm., and for globulin 1.4 to 3 Gm. The value for the total protein and the ratio of albumin to globulin are relatively much less significant in the appraisal of protein deficiency than the value for plasma albumin.

In the prevention and treatment of protein deficiency the administration of food by mouth remains the most effective method. When necessary the dietary intake can be boosted by giving amino acids (protein hydrolysates) by mouth or by tube feeding. In addition, supplementary administration of protein parenterally is feasible. For this purpose plasma can be used but yields relatively small amounts of protein (5 or 6 Gm. per 100 c.c.). Concentrated plasma albumin and hydrolysates of protein are more useful.

¹ Stare, F. J., and Davidson, C. S.: *J. A. M. A.*, 1945, 127, 985.

² Williams, P. F.: *Ibid.*, 1945, 127, 1052.

³ Stare, F. J., and Thorn, G. W.: *Ibid.*, 1945, 127, 1120.

⁴ Lund, C. S., and Levenson, S. M.: *Ibid.*, 1945, 128, 95.

⁵ Levine, S. Z.: *Ibid.*, 1945, 128, 283.

⁶ Cannon, P. R.: *Ibid.*, 1945, 128, 360.

⁷ Youmans, J. B.: *Ibid.*, 1945, 128, 439.

⁸ Turner, Dorothea F.: *Ibid.*, 1945, 128, 590.

⁹ Elman, R.: *Ibid.*, 1945, 128, 659.

In these days of food rationing and food shortages the prescription of a high protein diet is no simple procedure. Too many physicians are used to thinking of protein almost entirely in terms of animal proteins, particularly meat. All of us can benefit from careful study of Turner's article which deals with methods for providing

large quantities of protein-containing foods in the diet. She points out that at the present time it is not difficult to obtain adequate amounts of protein from unrationed foods. Attention to her methods is obligatory until steaks are again plentiful.

H. H. H.

PSYCHIATRIC WARDS IN GENERAL HOSPITALS

As an outgrowth of the current interest in psychosomatic medicine attention is being directed to the desirability of providing psychiatric facilities in general hospitals. The proposal is not a new one; indeed, what was perhaps the first general hospital in this country, the Pennsylvania Hospital, provided care of mental disorders as well. Since the Albany General Hospital in 1902 established its psychiatric pavilion, a considerable number of hospitals have followed suit—the Henry Ford, the Strong Memorial, the Massachusetts General, for example.

There seem to be resistances to the idea in certain circles, apparently stemming from the old prejudices handed down from medieval times with reference to mental disorder, and from the traditional separateness of mental hospitals with their special (and sometimes antiquated) methods of admission.

In the course of general hospital work numerous cases develop in which special facilities are desirable—the postpartum episodes, the acute deliria of senile patients or of patients suffering from some infection or other intoxications, postoperative confusional or depressive states, to mention the more dramatic. There are many other problems which call for psychiatric attention though not necessarily for close detention—the various hysterical manifestations, the mental changes associated with encephalitis, multiple sclerosis, and so on. Many of the acute episodes are brief, and the

family may well resent the suggestion that the patient be sent at once to a mental hospital; indeed, the transportation of such a patient may be contraindicated, yet his care in the general wards may be impractical. In the District an added difficulty exists, mainly that care in Saint Elizabeths Hospital for more than a few days after transfer from Gallinger Municipal Hospital requires commitment and an adjudication that the patient is an "insane person," voluntary admission being as yet not permitted by the law. A similar situation would not exist in transferring a patient to the psychiatric ward within a general hospital.

There are advantages to the staff, medical and nursing, as well as to the patient in incorporating psychiatry into the hospital scheme, as is well described in the book on this general topic by Dr. Franklin G. Ebaugh, published by the American Hospital Association in 1940.

No single step can have greater benefits to the patient, staff and public than a tangible recognition of the fact that the person being treated is a whole individual rather than an assemblage of parts, and that psychiatry is an integral part of medicine and not an isolated specialty, to be practiced only in remote institutions. The establishment of psychiatric wards in general hospitals is one of the significant trends in hospital administration today.

W. O.

AMERICAN MEDICAL ASSOCIATION OFFERS NEW PLAN FOR MEDICAL CARE

The American Medical Association's Council on Medical Service and Public Relations and its Board of Trustees made public a fourteen-point program "for the extension of improved health and medical care to all people" in the *Journal of the American Medical Association* for July 21. The program follows:

PREAMBLE

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

PROGRAM

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives.
2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.
3. Increased hospitalization insurance on a voluntary basis.
4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.
5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.
6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.
7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.
8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.
9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.
10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.
11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.
12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.
13. Adoption of Federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.
14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular Army, Navy and United States Public Health Service.

IRON TABLETS TO BLOOD DONORS

Since the inauguration of the Blood Donor Service to procure blood for military use, certain centers have been used as "pilot" centers to investigate methods pertaining to the taking of blood and to observe the effects of the donating of blood on the donors themselves. Early in the program investigators in the Columbus, Ohio, St. Louis, Missouri, and Detroit, Michigan centers began a study on the effects of iron on the regeneration of hemoglobin. These studies have now been completed and soon will be published in detailed form, but a few of the conclusions may be of interest at this time. First of all, it is apparent that less than 1 per cent of male donors have a hemoglobin level of lower than 12.3 grams per 100 c.c. of blood, which is the threshold level established by the American Red Cross for both male and female donors. Practically all of the eligible male donors, that is, those with hemoglobin above 12.3 grams, regenerate their blood quickly, and almost all of these attain their predonation hemoglobin level in 4 weeks or less. The investigation of female donors, however, showed somewhat different results. Approximately 10 per cent of women in the 18- to 60- year age groups who appear to make their first blood donation must be refused because they have less than the threshold level of 12.3 grams. Furthermore, those with hemoglobin above this level show a considerable variance in the speed of regeneration after a blood donation. Some form new hemoglobin as rapidly as males, but most of them take a longer time and a few do not reach their predonation level by the end of 8 to 10 weeks, at which time they may have made appointments for another donation. It was the two latter groups that were of particular interest, and it was found that hemoglobinogenesis was measurably and significantly increased by the taking of even as little as 5 grains of iron daily.

Apparently blood donors have an increased demand for iron that can be in a sense compared to the increased demand for iron known to be present in the last trimester of pregnancy. In the latter it is almost universal practice to prescribe iron to maintain iron reserves, and it is apparent that many blood donors likewise will benefit by the supplemental use of iron.

Beginning the week of July 22, 1945 the American Red Cross Washington Blood Donor Center is offering to each female donor an envelope containing approximately one hundred $2\frac{1}{2}$ -grain tablets of a ferrous salt. No insistence is made that she take the tablets, which will be given only to women who have just completed a blood donation. Under no circumstances are iron tablets distributed to anyone who is rejected as a donor because she fails to meet the hemoglobin standard. Objections may be raised by women who have donated previously, but they will be, as in the past, referred to their own physicians.

The following is a copy of the inscription on the envelope which the donor receives.

AMERICAN RED CROSS BLOOD DONOR CENTER
WASHINGTON, D. C.

TO BLOOD DONORS:

A healthy adult can donate a pint of blood with the assurance that health will not be thereby impaired. After a donation the body forms new blood, and this involves replacement of (1) fluids, (2) proteins, and (3) red blood cells which contain iron. A normal diet furnishes all the materials for the replacement of blood with the occasional exception of iron. Recently completed studies conducted by the Blood Donor Service have demonstrated that the addition of iron to the diet usually accelerates the replacement of red blood cells and their hemoglobin.

Therefore, tablets containing iron are being given to donors desiring them. The iron in the tablets is the amount in the pint of blood you have donated, and is therefore calculated to replace it.

Directions for Taking:

First day following donation—1 tablet before breakfast.

Second day—1 tablet before breakfast and 1 before lunch.

Third day and thereafter—1 tablet before each meal until all in this envelope have been used.

PHYSICIAN IN CHARGE

In and Out of Focus

BY THE OBSERVER

"A New Broom—" Change may not be synonymous with progress, but it is refreshing. And it usually inspires the hope that better things lie ahead. That being so, it is not surprising that toward the close of an organization year members of medical societies should look forward with pleasant anticipation to a change in administration.

Such an event took place on the first of July when the new officers of the Medical Society of the District of Columbia, headed by President William Earl Clark, assumed office. Immediately thereafter when committee appointments were announced, it became quite clear that things will be different in the coming year. For it was discovered that many new names appear on the roster of committees.

It is stimulating to the physician interested in his medical organization to observe the performance of enthusiastic neophytes. There is always the possibility that a few potential leaders will be discovered. With regard to the coming year, it can be reasonably expected that among those who will for the first time serve on committees of the Society there will emerge two or three who will stand out as men of ability and talent for organization work.

In making sweeping changes in committee personnel, the President stated he hoped there would be better attendance at meetings. In fact, he asked each appointee in accepting to indicate whether he could ordinarily be present at meetings called by the chairman. If not, he requested he be informed to this effect so that

there would be as little "dead wood" on committees as possible. At the time this is written no appointee has indicated that he would be irregular in attendance.

Now as to the policies of the organization it can be assumed that they will not change materially. Ours has been one of the most progressive state medical societies in the country. It will undoubtedly continue to be so. The organization structure is such that continuity of effort is assured. This is exceedingly important because where most groups, and individuals for that matter, fail is that their efforts are sporadic, without direction or a definite goal.

So, in beginning of another organization year, there is every reason to be optimistic in the knowledge that although many older heads who have demonstrated their capabilities and who have wide experience are being retained, yet new blood is being injected into the organization. What is equally important, there is every indication that the Society will pursue the progressive course it has followed for several years.

★

"Tomorrow's Psychiatrist" Progress in plastic surgery during the last war is comparable to the strides made in psychiatry in the present conflict. Despite achievements in the psychiatric field, those practicing this specialty readily admit that the exploration of human behavior and treatment of its abnormalities are still in their infancy.

Observations of Eli Ginzberg, Director of the Resources Analysis Division, Surgeon General's

Office, War Department, appearing in the *Bulletin of the Menninger Clinic* for March, confirm this opinion. Justifying a discussion of the subject by a layman, Mr. Ginzberg writes:

"Psychiatry—broadly defined—is more than a medical specialty. It contains within itself great potentialities for broadening our knowledge, not only of the sick man but of healthy communities and nations; it can strengthen the base of moral and ethical theory; above all it can contribute greatly to improving the mechanics of social reform."

He then offers his conception of the manner in which psychiatry can be of the greatest service to society.

"To the outsider looking in, psychiatry has come a 'fur piece,' but it is really at the beginning of the trail—and the road ahead is uncharted. But some sense of direction can be secured if not from psychiatry, then from allied branches of medicine. It is generally recognized that for every gain in individual therapy there has been a ten- or hundred-fold gain in preventive medicine. Even during the current war, the many advances in traumatic surgery will probably be overshadowed by a simple powder—DDT—which can so effectively cope with so many of the enemies of man. Without falling into false dichotomies, it is to preventive rather than to therapeutic psychiatry that one must look for the most startling advances in the coming decades.

"Once the psychiatrist admits that much of his work will have to be done outside the four walls of his consulting room, it behooves him to consider carefully the setting in which he will operate. The competent epidemiologist never goes far afield without consultation, probably collaboration with his engineering confreres. His problems can usually be solved only by tempering the discoveries of the medical laboratory to the practicalities of the engineering world. The psychiatrist who is concerned with preventive measures must, therefore, review and appraise the media through which he must work.

"Without establishing an exhaustive list, four major institutions can be enumerated of primary concern for preventive psychiatry as of the present moment: the church, the school, the Army, industry. These are the cauldrons in which the minds of successive generations are shaped. To this list must be added, of course, the most important and elusive of all—the family. The approach to the family will always be circuitous—through the physician, the social agency, the adult educational group."

Mr. Ginzberg comments on factors which will contribute to progress in psychiatry as follows:

"It is very much of a paradox that the offerings of psychiatry were spurned by the medical profession for a considerable time and even at this late date the former negativism has not really been dissipated. But if psychiatry is to broaden its field of endeavor, it must win the wholehearted support, if not of this, then of the next generation of doctors. Even in this day of specialization, the family physician remains a potent influence. He serves not only as the healer of the sick but also as the confessor to the troubled. As practicing physician, he should be psychiatrically minded; as confessor, he must be. One battle that psychiatry must win is in the medical schools of the country. It is apparently making progress, but a renewed drive is overdue.

"Much is said about the waning influence of religion, and much of what is said can be documented. But it would be an error of serious proportions to neglect the ministry in seeking assistants. For the tens of thousands who have no membership in a church, there are millions who do. Every day, ministers of every faith are working to condition the attitudes and feelings of their parishioners. What is more, they spend a considerable time in psychiatric consultation . . . Clearly, work along this front must be pushed aggressively if one of the potentially strongest allies is not to be lost and turn into an unfriendly non-belligerent if not an active enemy.

"Family physicians and ministers have their work cut out largely with adults. But if preventive psychiatry is to make progress as speedily as possible, it will concentrate on children, especially younger children. This means that the approach to school teachers becomes of paramount importance. Not only must psychiatric training be an integral part of the curriculum of every normal school, but child guidance clinics should be a part of practical demonstrations, their operations and value understood by all who go out to teach.

"According to the best psychiatric doctrine, late adolescence and early adulthood offer much more serious obstacles to correcting a skewed personality than does early childhood. But if the job is not done before ten, there is no reason to sidestep it at twenty. Military training is here probably to stay, at least for a long while to come. Every 18-year-old male will be screened for military service, and the vast majority accepted. The screening process will present a unique opportunity to spot individuals in need of psychiatric assistance . . .

"Except for a few millionaires and a few relief clients, most men and an increasing number of women live the greater part of their adult years under the dictates of their job. The competition of the market place is fre-

quently intense. Sheer survival is difficult; satisfactory adjustments rare. Yet, individuals have differing talents and differing aspirations. The wrong man in a good job cannot be a happy man; and the right man in a poor job likewise cannot be a happy man. Perhaps most men cannot be happy in their work. A great many can if industry learns that malassignments leading to friction and frustration are frequently correctible. Psychiatry has much to offer modern industry."

Speaking of the limitations of the present-day psychiatrist, Mr. Ginzberg observes:

"The psychiatrist has come out of his consulting room. But is he able to operate successfully on the faculties of theological and educational institutions? Can he communicate effectively with the technically-minded military man and the profit-preoccupied industrialist? In short, is the psychiatrist able to venture forth on an expanded program of preventive- and therapeutic-psychiatry with the training which he has received to date? The answer must be an unequivocal 'No!'

"To work through the specific problem of a patient in the consulting room almost always involves a careful and detailed reconstruction and evaluation of the individual's life's history. If psychiatry is to go afield and work through established social organizations and through the leadership of these organizations, psychiatrists cannot escape the obligation of understanding the highways and byways of these important institutions. No more pithy illustration of the inadequate training of present-day psychiatrists for tomorrow's work can be offered than the recital of a recent incident when a competent psychiatrist branching out to deal with the analysis of a nation, approached a professor of history on the prospects of collaboration with the suggestion that he would contribute the psychiatry if the professor would furnish the historical details!

"The history of our own society and what is equally important, if only to avoid unwarranted generalizations, the history of other societies must be part of the equipment of every psychiatrist whose preoccupation will extend beyond the asylum's fence or the analytic couch.

"The life of men in groups is the most complicated of all forms of life. It is not easily understood. But it must be studied and evaluated if the psychiatric specialist is to influence effectively men in other pursuits."

And Mr. Ginzberg concludes:

"Philosophy and history are definite requisites for tomorrow's psychiatrists. No amount of pathology and neurology can be substituted. Equally, if not more important, is training in scientific method—in working

up data and testing results which would permit the critic to distinguish insight from truth. Modern statistics in its broadest implications should be a 'must' for all who are trained today. The western scientific world from physics through sociology adheres to certain canons of logic and procedure. Psychiatry cannot come into the fold and at the same time stay out. Psychiatrists must be trained so that they can distinguish the interesting case history from a valid generalization.

"To accomplish their expanded mission, psychiatrists must not only win the tolerance of parents, educators, theologians, military men, labor leaders and industrialists, but they must gain their active support. This will be at best a task of great difficulty. To the extent that psychiatrists improve and increase the tools in their kit, they have a chance of succeeding. They need help.

"Universities are uncertain as to their next move; foundations are undecided as to the worthwhileness of competing requests for assistance. Two things are clear: Universities should realize that psychiatry is more than a medical specialty to be sandwiched in between medicine and neurology. Psychiatry is of concern to other than medical students. Recognizing these facts, universities should act accordingly and establish psychiatry as one of the strategic psychological disciplines which can contribute to and advance by close association with allied branches of learning."



*"I Would . . .
Keep My Old
Japanese
Patients"*

As our war with Japan nears its climax, we understand the people of that nation less and less. Their disregard for what we and most other peoples look upon as civilized behavior has been incomprehensible to our citizens. The reasoning—if there be any—which has impelled them to brutality, wanton destruction and mass suicides is, to say the least, mystifying to the occidental mind. What manner of people are these to whom life means so little?

Not so long ago one of our famed military leaders who had served long in the Pacific said that the Japanese were removed from the animal state by only a thin coat of veneer. He spoke with the depth of feeling of one who had fought an enemy showing no quarter nor abiding by any rules of warfare. His bitterness was understandable, but his outlook was that of a fighting man. Somehow we must view the Japanese

problem objectively and see it in its proper perspective. Many of the Japanese in this country, we are told by the Government, are loyal and upright citizens. Much has been written about them, but so far as your Observer can recall, none of these contributions have been by physicians. However, in the July issue of *Harper's Magazine*, there appears an article by Dr. Charles Miner Cooper, Emeritus Professor of Clinical Medicine at Stanford University, and a San Francisco physician for forty years, entitled "My Japanese Patients."

Dr. Cooper asks himself, "What kind of patients do the Japanese make?" Before proceeding to answer that question, he recalls how he came to acquire a large Japanese clientele. Some years ago he said he was called into consultation to see a Japanese patient "who appeared to have, and yet apparently did not have, pulmonary tuberculosis." Dr. Cooper determined that the patient was a victim of fluke disease of the lungs, which is not uncommon in Japan. A report of the case was published in a medical journal, and an interpreter, who was "a sort of shepherd to the sick Japanese in northern California, began to spread news of the incident among his people," and as a consequence many Japanese patients were brought to Dr. Cooper.

Describing the behavior of his patients, Dr. Cooper says:

"They would lend themselves without demur to any method of examination however disagreeable it might be. It would, however, take a little longer than usual to test their pupil reflexes, as in many of them there was but little contrast between pupil and iris. Moreover, many of them would repeatedly roll their pupils away from the beam of the examining light, and I would have to ask the interpreter, time and again, to tell them to keep their eyes open and motionless, which he would do with the manner and voice of a drill sergeant. They were otherwise admirable patients and they would follow to the letter the instructions given them through the interpreter, and for periods that would have palled on most Americans."

One thing Dr. Cooper learned was that the Japanese face the inevitable stoically.

"I always told the interpreters the literal truth, never disguising the significance of a finding, a diagnosis or a prognosis. Thus, after I had examined a patient who had a pyloric carcinoma with a distant metastasis, I, in answer to an inquiry by one of them, would reply, 'Patient have cancer stomach.'

" 'You cure?'

" 'No. Nobody cure.'

" 'How long he live?'

" 'Maybe six months, maybe one-two year.'

" 'You do anything for him?'

" 'Yes. Can make opening in stomach to let food get out. Make easier for him.'

" 'You think good for him?'

" 'Yes.'

" 'When?'

" 'No hurry. When he ready.'

" 'How much cost?' . . .

"Then he would talk to the patient, for a few minutes.

" 'What you tell him?' I would ask.

" 'I tell him he have cancer stomach; he no get better; he live maybe six months, maybe one-two year; operation no cure but make him more comfort. He come back when he ready.'

"I never saw one of these patients who had been told such a dire truth change his expression, or his bearing, and they retained their composure as far as I could tell to the very end."

The average American does not think of the Japanese as having a sense of humor.

"One day, some twenty years ago," Dr. Cooper relates, "this interpreter brought a patient who had severe, right-sided abdominal colic. Within his right kidney, as outlined on an X-ray film, was the shadow of a stone.

" 'What do?'

" 'Must take out.'

"A brisk conversation in Japanese was carried on. Then from him to me: 'Patient have cousin. Surgeon in Tokyo University. He go there to be fixed. You give him picture to show cousin?'

" 'Yes.'

"Some months later they both came again to see me. The interpreter reported: 'He go Tokyo see cousin. Show him picture. Cousin say, "Yes, you have stone; I make operation." He make it. He no find stone. Patient stay hospital six week. He have no pain. Then he get up. Pain come back and now very bad. What do?'

" 'Tell him take off clothes.' This he did. Then I said: 'His cousin make operation wrong place. He think patient have gallstone. He have kidney stone.'

"The interpreter told the patient what had happened, and then both laughed almost uproariously to think that the latter had gone several thousand miles to be cut open in the wrong place by his cousin. The stone was later removed in San Francisco."

Dr. Cooper says that he is no longer in active practice and is turning his patients over to an associate. He sees them now only in consultation. But he avers, "I would have liked to keep my old Japanese patients, so easy had it become for me to look after them." Nevertheless he is not unmindful of the guilt of the Japanese people where the war is concerned.

"I feel I owe it to myself to say that the appreciation I have expressed of my former Japanese patients as patients, and of their interpreters as shepherds of them, does not blind me to the fact that there is another Japan—a Japan which of late years has been controlled by an all-powerful upper crust, as ruthless, as brutal, and as menacing to world peace as Hitler and his following, an upper crust which by means of false, vicious propaganda has made the Japanese people believe that we are predatory and merciless and the mortal enemies of their legitimate aspirations, thus inflaming them to actions which such a belief incites. This propaganda the Japanese living in California during the period of which I write escaped, and I would expect our way of life to have so 'conditioned' the large majority of their American-born-and-bred children as to render them immune to such falsities."

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Despite high standards maintained by our medical schools, there are and undoubtedly always will be deficiencies in the training of medical students. For example, your Observer has long deplored the fact that most medical schools restrict the training of students nearly exclusively to scientific subjects. As a result most young physicians enter practice with little or no conception of how to establish a practice, conduct an office, or keep adequate records, to mention just a few subjects the knowledge of which would fortify and guide him when he enters upon his career. The question arises whether medical schools are indifferent to the

need for such training or whether they feel it is unimportant. It is your Observer's belief that, like others, the medical educator should from time to time take stock of his institution and assure himself that it is providing an adequate and well balanced curriculum for those who pass through its doors.

Writing in the *New England Journal of Medicine* for June 21, Dr. Egon E. Kattwinkel directs attention to what he considers serious defects in the present medical educational system.

"I have been impressed in observing the students under my care," Dr. Kattwinkel writes, "with a real deficiency in their knowledge of what constitutes the art of medicine. They are imbued with a hot devotion to the science of their profession, showing keen interest in the technic of diagnosis, with special emphasis on laboratory and other technical aids, but when questioned about the social history of the patient or the minute details of treatment on which the practice of the care of the patient so often depends, they answer in generalities that indicate a lack of an appreciation of the importance of such knowledge. Their feeling doubtless is that this is the province of the Social Service Department. They will find that when they leave the security of the walls of the hospital or of the Army they will have to be their own social service department or else be content with a meager practice—that is, if there is any degree of competition when they arrive at that golden day."

Part of the present difficulty, Dr. Kattwinkel admits, is due to wartime conditions.

"Unfortunately today, because of the shortage of physicians, the public is willing to put up with treatment minus the art as they put up with mediocre services at every turn. The doctor does not have to sell himself to his patients as he did—to be sure, usually unconsciously—in the past. It has been said that any doctor can build up a large practice if he possesses a good bedside manner, but that does not indicate how badly he practices it. This temporary upset in the balance of supply and demand removes one incentive toward the study and practice of the care of the patient, and the fact that most medical-school graduates are going into the armed forces removes another, at least in the minds of many. Too many fourth-year students believe erroneously that military medicine is cold and efficient and spurns any thought of the finer sensibilities with which the art of medicine is concerned. I have had occasion to talk to wounded

men of the Marine Corps who have returned from the South Pacific, and their glowing tribute to the medical officers who treated them stressed the humaneness with which they were handled even above the technical skill which was used. As one of them stated, 'He was my best friend—and I mean friend, not doctor.' The need for the art of medicine is universal.

"One other obstacle is that it takes more time and energy to practice this kind of medicine. Osler has said the man most to be pitied is the forty-call-a-day man. It is well-nigh humanly impossible adequately to care for the patient on that schedule. Corners must be cut to get through the day, and the more difficult features of practice—those relating to the understanding of the patient as a person—suffer. Such a man easily sinks to the level of a pill dispenser or at best a mere diagnostician. Even the man with a less crowded day avoids the exacting demands of the care of his patients. The best of us are fundamentally lazy, as someone has said, and we try to avoid that which taxes our time and maximum ingenuity. It is easier to get in and get out of the sickroom quickly, dodging the endless questions, the answers to which constitute in part the adequate care of the patient. It is, however, true that there are some patients, especially those in the lonely psychoneurotic group whose stereotyped questions waste the doctor's time, their solution adding nothing to the real care of the patient except as it acts as a pleasant interlude in the boring hours of the sickroom. It takes a real artist to handle such patients satisfactorily."

Dr. Kattwinkel has some suggestions for the physician. He proposes:

"In the first place, it is wise for him to be a student of man himself. This he may do by reading about, observing and talking with his fellow man. Provocative books such as Alexis Carrel's *Man the Unknown*, Fosdick's *On Being a Real Person* and Zinsser's *As I Remember Him* are helpful. An interest, limited as it may be, in his community life demonstrates how the men outside the profession think, talk and live. A close nonmedical friend or two will serve as a stimulant to argument, especially in front of an open fire, and will help crystallize ideas previously shrouded in foggy generalities. A study of religion will help the neophyte to understand that vital force which is so important in many lives.

"In the second place, he should acquaint himself with the literature of those men who have pondered the subject, notably William Osler, Francis W. Peabody, L. Eugene Emerson and Alexander Gibson. I know of no man of medicine who had a fuller, busier life than Osler, yet all his biographers agree that he never lost the human

touch.... At one time he was walking through the operating room of a Philadelphia hospital when an old man, a pauper, was about to have an ingrowing nail cut out. The old man was frightened nearly to death. When Osler grasped the situation he amazed the students by his rage when he said: 'Don't you dare touch that old man. You can do him no good, and you know it. Take him back to the ward.'...

"Too much laboratory investigation and prolonged hospitalization are often not in the best interests of the patient. In the anxious patient with a functional disease, they make him suspect that the doctor is unable to locate the trouble and that it must therefore be serious and deep-seated. In the older patient, the laboratory investigations use up the patient's strength and deplete his pocketbook. At best they only satisfy the ultimate scientific curiosity of the doctor and seldom add information that improves the quality of treatment. The best interests of the patient are usually served by a rapid thorough workup, including only definitely indicated laboratory studies. For example, what is the need of a urea-clearance test, phenolsulfonephthalein test and even a nonprotein nitrogen determination if an eighty-year-old patient has a specific gravity in the urine of 1.020 without appreciable albumin or formed elements in the sediment?

"There is also the danger of meddlesome medicine. Withholding from the old patient his few comforts such as tobacco, alcohol, coffee and certain items of diet just because this is theoretically sound from the point of view of the disease may at best add only a few weeks of unhappy life....

"Finally, the student who sincerely wants to perfect his technic in the care of the patient will find numerous examples exhibited by the older men in the profession."



Wartime Increase in Births

A poll would undoubtedly disclose that although he has no statistics to support his opinion, the casual observer believes that births have greatly increased during wartime. There are many reasons why he has come to this conclusion. To begin with, he has read a great deal in the newspapers about hasty wartime marriages. Much publicity has also attended the birth of children whose fathers in the services have never seen them. If he travels, he sees young mothers with small children wherever he goes. Then, too, he observes more evidence of promised births on the

street than he did before the war. Naturally he concludes that the birth rate has spiraled upward.

The *Statistical Bulletin* of the Metropolitan Life Insurance Company supports with figures what the ordinary citizen has long believed to be true. The *Bulletin* says:

"The number of babies born in the United States increased by about 25 per cent between 1940 and 1943, reaching a record high in the latter year. The figures show striking variations, however, when considered in relation to the age of the parents.

"Families in which the father was under 20 years of age had the largest relative increase in births, amounting to 65.5 per cent between 1940 and 1943 . . . the amount of rise varied also with the age of the wife. Where, like her husband, she was under 20, the increase in births was 64.8 per cent. Where she was between 20 and 24 years, the father being under 20, the rise was even greater, namely, 74.1 per cent—a figure higher than that found for any other age combination of husband and wife.

"When the comparison is made for families in which the mother was under 20 years of age, irrespective of the age of the father, the wartime increase in births was fairly small, namely, 14.2 per cent. It was more pronounced where the mother was in the age groups from 20 to 39 years, the increase here being roughly 25 per cent.

"One of the surprising findings in this study is that in families in which the husband was under 40—that is, in the military ages—the greatest increase in number of births from 1940 to 1943 occurred where the wife was either in the same age group as the husband or in a group five years older. This has already been noted for husbands under 20, where the rise was largest when the wives were of ages 20 to 24. But also among husbands of 25 to 29, the greatest rise is found where the wives were 30 to 34. As another example, we find that where the husbands were at ages 30 to 34, the group with wives 35 to 39 had the most rapid rise in births."

The *Bulletin* confirms another widely accepted belief:

"The general upward movement in births for all age combinations of husbands and wives, except the few just noted, was induced, for the most part, by recent marriages in anticipation of active military service, and by the economic prosperity resulting from war activities."

But the *Bulletin* cautions that in evaluating this situation we must consider the fact that the

increase among the very young parents "may be regarded, for the most part, as anticipated births which would have occurred in ensuing years in the normal course of events. The current gains in population through our high war-time birth rates are likely to be offset, at least in part, by a reduced birth rate in the postwar decade. There is no indication of any reversal in the long time trend toward smaller size of families."

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The Medicine Show Rolls On

Periodically for nearly twenty years your Observer has unburdened himself on the subject of fakers in the health field. Apparently he might as well have talked to himself. This applies with equal force to others who speak with much greater force and authority.

An agency which has outstanding accomplishments to its credit in this field is the Bureau of Investigation of the American Medical Association. Time and again the Bureau has exposed patent medicine sponsors without regard to the cost. The Federal Trade Commission has also cracked down on promoters of questionable drugs and cure-alls. But the "medicine show" still rolls on, with this difference, that from a small fry enterprise it has grown into big business proportions.

In view of past experience, there is little use of becoming impatient. Gradually the public will become enlightened. That day would be hastened, however, were it not for the air of respectability given the "medicine show" by radio stations and networks. Those who control the destinies of broadcasting cannot disclaim responsibility. They are intelligent men and know only too well the danger inherent in false claims for so-called patent medicines and cure-alls. They are obligated to determine the value of a product which they help promote and in so doing to seek expert advice. However, for obvious reasons, they have taken the easier road.

Your Observer recalls numerous conferences with a manager of a radio station in a Midwestern city with regard to drugs being advertised on the air. Some of them were removed. The least questionable ones were not. Even those dropped were restored when the advertising manager believed that there would no longer be any protest from the medical profession, which he should have known—and perhaps did—had no interest in the matter other than protecting the public health.

Radio performers should come in for their share of criticism, too. For they give the impression that they tacitly approve ridiculous claims. One wonders how they can stand before the microphone and listen to the commercials without twinges of conscience. Your Observer is thinking of a nationally known commentator whose sponsor has been under fire of the Federal Trade Commission for some months past. He has, he says, lofty ideals, but they do not extend to the firm that sponsors his appearance.

If the public is gullible, it is less a cause for regret than the dishonesty or the indifference of those who lend themselves to the promotion of quack remedies. Even in the palmiest days of the "medicine show" racket there were never any sillier claims made than today, and the "show" had not gone high-hat making such pretensions as it does now.

Medical ethics are frequently spoken of with disdain by those who say that they are not observed. It is, of course, true that there are physicians who ignore them. But it is our belief that they are very much in the minority. It is certainly true that infractions are not condoned by medical societies. On the other hand, the "ethics" which govern radio broadcasters which permit the "medicine show" on the airways never has risen to a level where it is comparable to the physicians' code. As potent an instrument for good and evil as the radio should be required to make a serious attempt to come within striking distance of it.

Emphasis on Professional Relations Needed

There is no well organized medical society in this country which does not have a committee on public relations. This is undoubtedly due to the fact that much has been written and said about the importance of stimulating friendly relations with the public. Some of the public relations programs sponsored by medical societies have lived up to expectations; others have enjoyed dubious success.

It is not your Observer's purpose to go into the details with regard to these programs, but merely to call attention to the fact that, unless physicians understand and support the views presented to the public by their representatives, it is so much wasted effort. As every well informed official of a medical society knows, it is extremely difficult to arouse the active interest of physicians in vital issues confronting medicine. They are inclined to leave such matters to their chosen leaders. But obviously they cannot be solved by a few. Leadership, important though it is, does not get very far without support of the rank-and-file. This is certainly true where public relations is concerned.

Your Observer has discussed this subject with many medical leaders, and the comment most frequently heard is this: "We will not encounter any difficulty with the public. The doctors have to be sold on our program and it will not be easy to do." Similar views have been expressed by those responsible for the conduct of experiments in providing medical care. Not so many months ago your Observer visited a city in the Midwest where a successful prepayment medical service plan is in operation. He was told not once but many times that the greatest difficulty encountered had been with doctors participating in the plan. Too many who had agreed to participate did not take the trouble to learn what was expected of them. In consequence, there were misunderstandings and complaints. Small groups had been formed to impede the progress of a vast and difficult under-

taking. Surprisingly this plan is successful despite the indifference and lack of support of a substantial minority of physicians. Eventually this situation will be remedied, but how unnecessary the waste of time and effort.

The laity reads a great deal these days about medical care, more so than doctors realize. Nearly every periodical includes an article or two during the year dealing with some phase of medical socioeconomics. It is, of course, true that professional publications such as the *MEDICAL ANNALS* also bring to its readers information on this subject. But so far the public has been much more interested than physicians. This is not a healthy state of affairs. What is needed is an adequate professional relations program, one which will arouse doctors from their lethargy.

In the next few months our Medical Society will put forth every effort to see to it that its members fully understand why the future of medicine here as elsewhere is at stake and what must be done about it. There is little use of going to the rank-and-file of the public with our problems and plans unless physicians are prepared to lend their support.



*Members
Decry
Commercial
Practices*

In last month's issue of the *MEDICAL ANNALS*, Acting President William M. Ballinger devoted his President's Message to commercial practices in medicine. Pointing out that much of the criticism leveled at the medical profession is due to the conduct of a minority, he urged that physicians charge a fair fee for their services; that if the patient thinks his bill is too high they reduce it; that they speak to the patient if the patient is to incur a large bill; and that legal action to obtain compensation for their services be not taken except under circumstances that fully justify it. Dr. Ballinger reports that many physicians have spoken to him about his message indicating their approval.

And well they might for, as one nationally

known medical leader said to your Observer some months ago, "Physicians who make exorbitant charges have helped to bring on the demand for state medicine. Though comparatively small in number, there are too many and it hurts." This festering sore in the medical body should be removed. Small though it may be it has produced a severe systemic reaction. It is well enough to say that only a comparatively small group commercialize medicine, but they have brought condemnation and suspicion on their fellow practitioners which will not be readily eradicated. Older physicians are not entirely free of guilt. However, it appears that most of the difficulty does not lie with them. They are much disturbed by the invasion of commercialism in medicine and well aware of its dangers. Younger physicians may not view so seriously the result of charging all the traffic will bear. This has, in the opinion of your Observer, been due in a large measure to the failure of medical schools to prepare their students adequately with respect to the manner in which they should conduct the business side of their practices.

There has been criticism of Washington physicians because of their fees, no more so undoubtedly than of those in other large cities, but too much for comfort. Not long ago your Observer received a letter from a Midwestern physician. He wrote that a daughter of a close friend working in Washington had, in his opinion, been charged an excessive fee for medical service. He said some very uncomplimentary things about the medical profession in the Nation's Capital. Most of his remarks were not justified, but nevertheless that is the way he felt. Which goes to prove the effect of one unpleasant experience and how the conduct of a few reflects on the conscientious and fair medical practitioners who constitute the majority.

If physicians are to retain the high public esteem to which they have long been accustomed, they must purge themselves of "business doctors."

Children's Health Threat to Peace?

Views on the state of the children's health in Europe during the war have appeared on one or more occasions in this column.

What is the situation since the defeat of Germany? Is the health of the children a threat to Europe's peace? Adelaide Kerr, correspondent for the Associated Press, writes:

"Psychiatrists say millions are suffering from varying degrees of mental and emotional disorder. When discussing the cure for these psychological ills, psychiatrists point out that one of the most important factors to mental health is a good physical background.

"But reports indicate malnutrition stalks Europe's children like a specter. Tuberculosis is a major menace. There also are widespread reports of stomach, intestinal and skin ailments, rickets, diphtheria, spinal meningitis, melancholia, apathy, insomnia and neurosis.

"Thousands, lost from their families, hiding in forests, caves and swamps are now emerging, naked and emaciated."

Reporter Kerr relates a story told her by a United Nations Relief and Rehabilitation administrator that a 6-year-old girl at an UNRRA refugee camp near Cairo was found in a cave in Dalmatia.

"She was wild," the administrator said. "They had to catch her. She wouldn't talk; wouldn't sleep in a bed. She ate nothing.

"When they came to El Shatt they put her in a hospital. She slept on the concrete floor. They couldn't wash her; she wouldn't allow herself to be touched. . . a little boy started the cure. One day the little girl came up to his bed, touched him, then took his food. After that she wouldn't eat anything unless he gave it to her. Now she sleeps on the floor about once a fortnight."

Dr. Oto Almoslino, serving as a physician at a refugee camp in the Middle East, says:

"We can have much hope for the physical rehabilitation of these children. First it is most essential to let the children have food they like and are accustomed to. Second, with new and clean clothes—especially shoes—they are unbelievably happy. It is one of the ways to let children forget."

Yes, Europe's children are in a sad plight. They must not be allowed to suffer more than

they have if we are to have a healthy, normal generation tomorrow.

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A Serious Situation

Immediately following his discharge, the returning service physician seeks a place to practice his profession. Perhaps an office may be held for him by a colleague, but usually he must find new space adequate to his needs. That is a large order in Washington today, for office space like housing is at a premium. Immediate relief, unfortunately, does not seem probable. Regardless of this, something has to be done and that soon to assure our veterans that they will have an opportunity to reestablish themselves when they return.

Upon inquiry your Observer has learned that many physicians in the European area will be coming home this fall, a limited number to return to civilian life. It is therefore not too early to prepare a place for them in the community. This fact is recognized by the Committee on Service Physicians which, it is understood, will soon hold a meeting to discuss this and other matters. Surveys have already been made to determine how many physicians now engaged in practice in Washington will share their offices with returning physicians. A fair number have said that they would be glad to do so. However, when inquiries are made one finds the space inadequate or the hours when it is available inconvenient, if not undesirable. It is well that these facts have been determined now so that the Committee will be guided accordingly. As a first step the Chairman of the Committee has requested the Secretary of the Medical Society to write to the managers of the various medical office buildings to ascertain if they will cooperate by giving preference to returning veterans. It is to be hoped that the response will be prompt and encouraging.

Again, the Committee assures Society members in the armed forces that it is determined to do everything in its power for those who have served their country so well.

*If Doctors
Advertised*

Washington physicians have become familiar with Ray Everett's tall, lean figure. Ray, who for many years has been Executive Secretary of the District of Columbia Social Hygiene Society, is the fortunate possessor of a genuine sense of humor. He is a poet of parts, too. All in all, he is an interesting person well liked by those who know him.

In the April issue of *Women in Medicine*, official publication of the American Medical Women's Association, there appeared a humorous item credited to Mr. Everett entitled, "Alice's Walrus Enters a Discussion—." Ray informed your Observer he had written it several years ago; however, it had been picked up again and published. It seemed to your Observer well worth including in his column. Here it is:

"Ethical considerations involved in professional ad-

vertising have aroused numerous verbal fires throughout the country. Many of the arguments add heat, not illumination, to the flames. But has anyone attempted to apply our modern publicity catch phrases to the activities of lawyers, doctors and their learned associates? Assuming 'No' for an answer, we list a few such applications for your idle perusal.

"Should advertising become permissible and prevalent among lawyers, for example, we might glimpse the following in our morning papers: 'When better wills are broken, Smith will break them,' or 'Jones serves the finest subpoenas in Washington. Ask Dad; he knows!' Or, again, 'The pen is mightier than the sword. Let Brown and Brown keep you out of it!'

"In the space devoted to physicians we might behold such items as: 'Send your little one to Doctor Smith for his tonsillectomy. Children cry for it,' 'See Doctor Jones when headaches floor you. Be nonchalant! Light a sinus!,' 'Patronize Doctor Brown; winner of every Kahn test,' or 'For skin disorders shake hands with Doctor Smoothie. The fin you love to clutch.'

"No need exists to seek an appropriate slogan for the mortician. What could be more fitting than 'Eventually, why not now?' And, with that, the matter rests."

PRAISE FOR THE MEDICAL DIVISION

WASHINGTON, D. C., July 18, 1945

DR. W. CALHOUN STIRLING, CHAIRMAN

MEDICAL DIVISION

D. C. WAR FINANCE COMMITTEE

WASHINGTON, D. C.

DEAR DOCTOR STIRLING:

Now that the dust of the campaign has settled and the last victory cheer died down, our Committee can see clearer and more properly measure the assistance it received in making a success of the record-smashing Seventh War Loan in the District of Columbia.

We do not pretend to be able to plumb the depths of, or otherwise measure the contribution made to the campaign by the Medical Division, of which you were the alert and able chairman. But we do know it was a very substantial contribution and one that heartened us during that doubtful phase of the drive when victory seemed to be just beyond our grasp. Certainly it is evident in the final results that our triumph

could not have been achieved without the million and one half dollars in war bond sales which you and the Medical Division made for us, sales that were some \$250,000 above the quota you voluntarily assumed.

To us there is special significance to the help you gave the Seventh War Loan. It shows the importance of coöperation. The contribution made by one group makes up the entire war finance effort when integrated to and combined with the contributions of other groups. Only when each group does its job well can we create a design for success.

We can think of no greater tribute to pay to you and others active in the Medical Division than to say that you all did your job well, and at a time when the exigencies of the war had overburdened you with many, many professional obligations. We are well aware how overworked medical men are today.

(Continued on page 392)

Washington Physicians of Yesterday



GEORGE MARTIN KOBER, M.D., LL.D.

Few Washington doctors of former years are as well known to physicians now in practice as Dr. George⁵ Martin Kober. Dr. Kober merited the recognition given him by his colleagues and the people of the District of Columbia for he was a tireless champion of both.

Dr. Kober was born March 28, 1850, at Alsfeld, Hesse Darmstadt, Germany. Educated at the grand ducal Realschule of his native town, he emigrated to the United States in 1867. Upon his arrival he secured an assignment to the Hospital Corps at Carlisle Barracks, Pennsylvania. In October 1871, he was ordered to duty in the office of the Surgeon General of the Army at Washington. He received his degree of Doctor of Medicine from Georgetown University in 1873, and Doctor of Laws degree from the same University in 1906.

Dr. Kober had a long and successful military medical career, beginning with his appointment as Acting Assistant Surgeon, United States Army, in 1874. Tours of duty took him to many Army posts throughout the country.

Upon his return to Washington in 1889 he was appointed State Professor of Medicine at Georgetown. In August 1890 he became a member of the International Medical Congress, being Honorary Secretary of one of its sections.

In the years that followed he was active in the public health field, among other things investigating the causes of typhoid fever in Washington.

The annual Kober Lectures have kept his memory alive in Washington medical circles. His nephew, Dr. William P. Herbst, is a well known Washington urologist and President-elect of the Medical Society of the District of Columbia.

Dr. Kober died in Washington on April 24, 1931.

SOCIALIZED MEDICINE*

Part II: The Trend Toward Socialization

Two hard facts, widely quoted, are sufficient to point up the relation that exists between finances and health: (a) for the ten most important diseases in this country, the death rate is approximately twice as high among poorly-paid unskilled laborers as among well-paid professional people; (b) the life expectancy of workers in industry is eight years less than those who are not employed in factories and mills. Hazards of employment, however, have a direct bearing on the span of life. Those who earn less are apt to work in an environment which exposes them to health risks more than people with high incomes. Even so, the urge toward Federal control of medicine stems from the force and significance of these conditions, despite the substantial private investment of capital in equipment, education and research by a gifted and conscientious profession.

There are many definitions of socialized medicine and its importance appears to depend primarily upon the professional bias, political ambition, emotional inheritance, and economic status of the individual. But the crux of all ideas is Federal control to a dominating degree; and the subject is discussed in this sense in the present analysis.

Government support of tuberculosis hospitals, and the free medical care of the indigent through taxation are, of course, forms of socialized medicine which have been in operation for several years. But basic institutional changes are needed, in the opinion of proponents of socialization, because the cost of modern medical science has put medical care beyond the private means of a large number of people. According to the National Health Survey of 1938, 90 per cent of the people in the country could not pay for their medical care unaided.

For complete medical and dental care the average family's health bill should be at least \$150, it is estimated by some authorities. But few families can afford to keep fit at that rate in the light of facts

developed in a recent report of a Senate Subcommittee on Wartime Health and Education. Choosing the year 1942 as an appropriate period for analysis, this committee found that there were approximately 33.4 million family units in the United States. Their income distribution is shown in the following table, together with the amount they spent for medical care:

Aggregate Amount of Income	No. of Families in Each Group (thousands)	Spent for Medical Care	Proportion of Income (per cent)
Less than \$1,000.....	6,900	\$42	6.8
\$1,000-\$2,000.....	9,800	68	4.5
\$2,000-\$3,000.....	6,800	96	3.9
\$3,000-\$5,000.....	6,700	143	3.7
More than \$5,000....	3,200	241	2.4

"The table indicates that even in the relatively prosperous year of 1942, 70 per cent of the families in the United States had incomes of \$3,000 or less and 50 per cent had \$2,000 or less," explains the Committee. "The average family expenditure for medical care was estimated at \$100, but families with incomes under \$3,000 spent considerably less than this. Nevertheless, the low-income families spent a larger proportion of their income for medical care than the higher-income families."

Here again, it is important to recall that the low-income family is frequently living on a sub-minimal or faulty diet which may lead to the physical complications requiring them to spend such a large percentage of income for medical service.

SHOULD SOCIAL SECURITY BE BROADENED?

The solution of the aforementioned problems, according to certain Congressional spokesmen, can best be found in a broadening of the Social Security law. A new bill, recently introduced for this purpose had these recommendations among others:

(1) A ten-year program of Federal grants and loans for the construction and expansion of new hospitals and health centers, especially in rural communities. A total amount of \$950 millions is involved.

(2) Grants to states for the expansion of welfare and health services and for public assistance to needy individuals, such as the aged, blind and dependent children.

* This article originally appeared in *The Index*, published quarterly by The New York Trust Company. Permission was granted to reprint it in this issue of the *MEDICAL ANNALS*. "Socialized Medicine Part I: Growth and Development of the Profession" will not appear in the *MEDICAL ANNALS*. Interested readers can obtain a copy of this portion of the article by writing the publishers.

Sponsors of the measure contend that the financial barrier to adequate hospital and medical care—viz., the unequal distribution of doctors and hospitals throughout the country—will be eliminated by this legislation. The health insurance system outlined, it is held, will enable people to obtain all needed medical care through small regular prepayments based on their earnings, will encourage doctors to settle in rural areas and communities and also spur the construction of needed hospitals. Some of the more vital provisions of the bill, as summarized by *The New York Times*, are the following:

- (a) Each insured person is entitled to choose his own doctor from among all physicians or groups of physicians in the community who have voluntarily agreed to go into the insurance system.
- (b) The doctors who participate are free to accept or reject patients and the participating doctors are likewise free to choose the method through which they are to be paid by the insurance fund.
- (c) Both patients and doctors may change the arrangements if they become dissatisfied.
- (d) All qualified hospitals are eligible to participate.
- (e) The Surgeon General is forbidden from exercising supervision or control over the management of hospitals which are not owned and operated or leased and operated by the United States.

The principle of economics known as Gresham's Law—"bad money drives out good"—is often cited in connection with discussions of the effect that government health insurance plans might have on the medical profession itself. Dr. Charles Gordon Heyd, Past President, American Medical Association, contends that this principle is equally important to the profession of medicine because under compulsory health insurance "poor medicine will eventually drive out good medicine."

"Applying this general principle to the distribution of medical services," he asserts, "we would find that under compulsory health insurance there would exist for a time two types of medical practice: (1) that rendered by private practitioners—a superlatively good but expensive service; (2) a more or less sub-standard type of service rendered by the government system. Eventually the sub-standard would drive out the superior type of med-

ical practice until all medical practice would be reduced to a common denominator lacking in effectiveness, in scientific attainment and dominated by rules and regulations of a medical bureaucracy."

MEDICAL PREPAYMENT PLANS

Doctors themselves are aware of the fact that they are in danger of being enmeshed in a government operated system unless they do something about it. In terms of practical economics, the question that confronts them is: Can the costs of medical care be met by the patient in a better manner than by the existing system of the individual fee payment?

The Medical Society of the State of New York represents the views of many other medical organizations in stating emphatically that tax paid compulsory Federal insurance, under the Social Security Act, does not necessarily assure the patient economic protection in illness.

"Federal insurance," asserts the Society, "will not be demanded by the public and the clamor for its enactment will die away if the doctors pull together and everywhere establish and maintain their own prepayment plan. The cost of medical care can be met by the patient through the insurance principle. Medical indemnity insurance is a solution within the reach of all patients. This form of prepayment has the strong endorsement of the Medical Society of the State of New York."

There has already been a widespread test of two major kinds of medical prepayment plans in the United States. The first, the group health association, provides for the employment of a certain number of doctors and then resells their services to the public on a prepayment basis. Under this arrangement known as the "vendor system," the doctor actually works for a corporation and the patient buys a product that the corporation sells. The medical profession generally has refused to approve of the group health method because the doctor's services are sold by a third party, thus destroying the age-old personal relationship of physician and patient.

A second type of prepayment plan is the voluntary indemnity insurance principle which does not sell the doctor's services but furnishes to the patient funds with which he can pay his medical bills. This plan enables the patient to go as usual to his own personal physician but the bill is sent to the office

of the indemnity organization. The doctor is then paid, on behalf of the patient, a certain fixed sum to meet the bill determined by the fee schedule. Amounts in excess of the sum provided by the indemnity plan and the sum charged by the physician are paid by the patient.

The indemnity plan makes special provisions for persons in the small income bracket. The plan stipulates—and it is agreed beforehand—that people in this group pay the doctor only the fee specified in the schedule, and no more. Such an arrangement is generally referred to as a “service” contract because it provides a definite amount of medical service without additional cost.

VOLUNTARY PLAN FAVORED

Many controversial questions have arisen in connection with the indemnity plan. What income group, for example, shall be charged only the sum stated in the fee schedule? Shall it be those who earn \$5,000 annually, or one-half that amount? The New York State association contends that the real difficulty is that no one yet knows the facts and cannot know them until the plans are in operation on a larger schedule.

“The doctor’s point of view,” says the Society, “is that he does not wish to continue to treat a substantial portion of the population for little or nothing and at the same time cut his rates to those who have hitherto paid him. Until it can be proved that a reasonable number of his charity patients have become subscribers to the plan, he is understandably opposed to a high income ceiling.”

Operating details of medical indemnity plans vary widely. Most of them start with the principle of enrolling employed groups, payments being made by payroll deductions. This spreads the risk and obviates the necessity of medical examinations before acceptance of subscribers. Employees who leave their jobs are permitted to continue as individuals. Costs differ in accordance with the character of the plan.

There are several hundred voluntary medical indemnity plans now in operation throughout the country. Probably only a small part of their potential success has been realized because the idea is still relatively new. The New York organization, however, finds these general advantages in the voluntary medical indemnity plan:

- (a) It retains the doctor-patient relationship unimpaired.
- (b) It keeps the practice of medicine in the hands of the medical profession.
- (c) It teaches the patient to budget for medical care.
- (d) It accords the patient the right to choose his own doctor.
- (e) It is within the reach of the income group that would welcome a means of remaining independent of charity.

HOSPITAL PLANS

Membership in hospital plans far outstrips that in plans having surgical coverage. Some 18 million persons have enrolled in the Blue Cross plan alone, a movement which started during the business depression in the early 1930’s and was endorsed by the hospitals because they were financially vulnerable. As many as 100 were forced annually to close their doors during these years. Today there are 78 hospital plans in the United States sponsored by the Blue Cross (Associated Hospital Service), and the total amount paid to 3,500 participating hospitals is approximately \$300 millions.

Benefits are guaranteed through contracts between each plan and the member hospitals in its area, and payments for service are made directly to the hospital. The advantage of the service benefits over cash indemnity, say Blue Cross supporters, is the flexibility of the coverage. Any plan which can soften a burden is bound to be greeted sympathetically by the public.

The legal status of the non-profit hospital and medical plans is still in the controversial stage, but activity has been concentrated and plentiful. Within ten years, 32 states and the District of Columbia enacted legislation governing the organization and supervision of non-profit hospital service plans, and 21 states enacted similar legislation for non-profit medical service plans. As late as 1939, a ruling had been handed down by 9 states, through their legal or insurance departments, that non-profit hospital plans were not “insurance” and would thus be permitted to operate under the general corporation laws, exempt from the regulations governing stock and mutual institutions.

More than 25 million persons currently receive substantial medical and hospital protection through

Blue Cross plans, industrial medicine and medical prepayment organizations. Certain leaders of the medical profession, however, believe that many of the plans are too narrow in their coverage. Some are confined to surgical and obstetrical care, some include medicine in the hospital and a few include comprehensive coverage including home and office care and preventive medicine.

EXPANSION OF HEALTH INSURANCE

Insurance companies have also made substantial progress in the development of plans to provide medical care for different classes of society. The growth of insurance from the first burial societies to an agency for providing safety and stability to all possible phases of human activity is clearly one of the epics of modern business. Success in other fields provided logical grounds for applying the principles of insurance to the hazards of health, sickness and disability. Expansion has been rapid, particularly during the war period. The business of stock companies alone in the accident and health field has more than doubled in the past four years. An even more startling increase is shown by the growth of hospitalization associations whose subscriptions increased from \$32 millions in 1940 to \$111 millions last year, a gain of approximately 250 per cent.

Insurance authorities state that hospitalization insurance, offered by both stock and mutual insurance companies, is the youngest and fastest growing major insurance line today. Hospital premiums helped make accident and health the largest insurance line in 1944 in the casualty and surety field, larger even than workmen's compensation and all forms of automobile insurance combined. Another reason for the growth of health insurance is the actual lengthening of the human life span. Average expectancy in 1850 was 40 years—today it is 64. Several insurance companies have instituted health education programs, with the certainty that any person who takes out health insurance will be interested in such information.

The rapidly expanding health protection of the group insurance companies is now an important part of the Nation's industrial development. During the war years an increasing number of large indus-

tries have developed health protection plans for their employees. Currently there are at least 18,000 companies who have insured their employees, in whole or in part, against various portions of the cost of medical care. More than 17 million people are covered by these plans.

MEDICAL INSURANCE IN FOREIGN COUNTRIES

A majority of foreign nations have gone much further than the United States in the establishment of medical insurance for employees. Forty-five countries, chiefly in Europe but including Chile and Japan, had installed—up to the outbreak of war—a compulsory form of social security with varying amounts of coverage. In most of these countries both the employer and the employee contribute and are sometimes backed up with considerable tax support. Employer contributions, plus tax monies, give the schemes the character of relief for the indigent, particularly since they rarely cover persons with incomes of more than \$1,500 to \$2,000.

In Great Britain about 80 per cent of the workers—which means 40 per cent of the population—are insured partly at their own cost, partly at the cost of their employers and the state. The principle of free choice of physician has been retained in principle, at the insistence of the British Medical Association. A sick subscriber thus consults a "panel" doctor whose panel may comprise from 1,500 to 2,500 patients—obviously too large a number for one man to handle successfully; and because of the perfunctory aspect of the consultations this feature of the system has been widely criticized.

Recently Britain indicated a disposition to expand this system, already 33 years old, by extending its coverage to the entire nation. Based upon the report of Sir William Beveridge, which in 1942 outlined a plan of "cradle to grave" social security, the Government issued a White Paper outlining details of a new social insurance plan which proposes widespread use of group practices. The Government's ideas are, in general, a modification of the Beveridge plan. Britain's estimated expenditure for health service in 1945 is £148 millions (\$592 millions at the arbitrary figure of \$4 to the pound). It is expected to rise to £170 millions in 1955 (\$680 millions).

The trend of action in England, as well as in other countries, has been from voluntary to compulsory

insurance, but in no case does action seem to move back to a voluntary system. Everyone in Russia is in theory entirely protected by medical insurance. New Zealand has had a system of socialized medicine since 1939, established at that time by the Labor Government. The consultation fee is \$1.50 for each visit with \$1 additional for night or Sunday calls and a mileage allowance for visits outside the doctor's own borough. This is paid by the state which also pays for most drugs and X-ray diagnoses and massage treatments.

WORKMEN'S COMPENSATION

The earliest form of social insurance in this country was workmen's compensation. This was advocated in the beginning of the century on the premise that industrial accidents are a legitimate cost of production and should be paid for by the employer, not the employee. State legislation began in 1911 and now all the states but Mississippi have laws compelling employers to insure their employees against industrial accidents and, in some states, against industrial diseases as well.

These laws differ in coverage, in rates and duration of compensation for time lost, in provisions for medical, surgical and hospital care, and in death benefits. Current proposals point to the extension of workmen's compensation rather than its limitation, in spite of recent criticism of abuses of the law which goes further in the direction of compulsory medical insurance than any other state or federal regulation.

There is no doubt as to where the majority of the medical profession stands on the broad question of socialized medicine with its attendant government controls. The House of Delegates of the American Medical Association, which is its policy-making body, has repeatedly gone on record in opposition to any scheme that would involve "political control of medicine" and is definitely opposed to what is generally referred to as "socialized medicine." The platform of the Association, with respect to this question, advocates in part:

"The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

"The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

"The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability."

OUTLOOK

The country's war experience in the field of health has clearly given impetus to the belief that the healing arts should be made available to everyone, irrespective of means. Another contributing factor is the desire of the Government to make certain that the best of medical care is brought within the reach of every veteran of this war. At least 1,500,000 and probably 2,500,000, will incur disabilities, it is estimated in Congressional circles. In addition, there are approximately 350,000 veterans of World War I. The health needs of these men will be a permanent responsibility of the American people.

In the postwar period, veterans of this and previous wars will constitute a large and important segment of the population. The number may well be 20,000,000, it is estimated, or one in every seven of the total population. Veterans with their families may comprise from one third to one half of our whole population. The concern which the Nation has for the medical care of veterans thus arises not only from an obligation to protect the future welfare of our fighting men and women, but also from the practical necessity of maintaining and improving the health of the whole people.

These considerations are of profound importance from the human standpoint. They have equally subtle and potent political implications. The notation must certainly be made that many persons who need medical attention are not receiving it because they cannot afford it. But will a socialized plan provide the service needed without greatly encouraging expensive government bureaucracy? Will the business of curing the country's sick become both the business of politicians and physicians? Will it lower the quality of medical services and medical research? Will it kill the incentive of young men who might normally wish to pursue a medical

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A LARGE AUDIENCE GREETES BRITISH SCIENTIST

Despite the intense heat on the evening of July 5, the Medical Society's auditorium was filled to overflowing with physicians and their guests. The occasion was the appearance of Sir Alexander Fleming, famed British scientist and discoverer of penicillin, who addressed the 500 or more persons present on the development and use of penicillin as a therapeutic agent.

Sir Alexander was presented to the audience by Dr. William Earl Clark, President of the Medical Society. Dr. Clark had previously introduced other honored guests seated on the rostrum. They were Rear Admiral J. C. Agnew, Deputy Surgeon General of the Navy; Rear Admiral R. E. Dyer, of the U. S. Public Health Service, Director of the National Institute of Health; and Major General Shelley U. Marietta, Commanding Officer of Walter Reed Hospital.



SIR ALEXANDER FLEMING

FLEMING, DR. CLARK

(Above) REAR ADMIRAL DYER, GENERAL MARIETTA, FLEMING
(Below) CAPT. McMAHON, REAR ADMIRAL AGNEW, FLEMING, CAPT. CRAIG

Prior to the meeting Dr. Oscar B. Hunter, Chairman of the Program Committee, had entertained Sir Alexander at a dinner given at the Mayflower Hotel. Guests at the dinner were: President Clark, Rear Admiral Agnew, Rear Admiral Dyer, Major General Marietta, Dr. A. S. McFarlane of the British Food Mission, Captain Alphonse McMahon, U.S.N.R., Captain Winchell M. Craig, U.S.N.R., Dr. Harold O. Hofmeyr, Captain George W. Calver, Colonel J. E. Ash, Drs. Walter A. Bloedorn, Alan J. Chenery, Roger M. Choisser, Paul F. Dickens, Robert H. Groh, Robert Scott Lamb, William Ross Morris, Maurice Protas and James W. Watts, Mr. John Cameron of the British Food Mission, and Mr. Theodore Wiprud.

Socialized Medicine

(Continued from page 381)

career? Or is medicine in the same position that education found itself a century ago—moving from a private to a public field?

Those who favor compulsion find only one answer to these questions. But those who regard freedom of opportunity one of the precious assets of America deny that government control of medicine is the conclusive answer. Louis H. Pink, President,

Associated Hospital Service of New York, admits frankly that the majority of the medical profession, as well as hospital and professional people generally—including the American Bar Association—feel that centralization of medical care might be a step away from the democratic concepts to which this country has adhered in the past.

Certain significant facts emerge from the violent controversial discussions surrounding the above

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War Section

SERVICE NOTES

Dr. Joseph Kreiselman, Consultant in Anesthesia to The Surgeon General of the Army, attended a meeting of the Second Service Command Anesthetists at which recently adopted professional policies were discussed, including treatment of respiratory depression and asphyxia.

Major George R. Farrell has been assigned to the Physical Standards Division, Professional Administrative Service, in the Office of The Surgeon General. Major Farrell recently returned from the European theater of operations.

SERVICE PHYSICIANS WHO HAVE RETURNED TO CIVILIAN PRACTICE

From time to time physicians have inquired at the Society's office about returning service physicians. How many have there been and who are they? Up to last month 15 of Washington's physicians were back in civilian practice. So far as is known, the following constitute a complete list of those who have been discharged and are no longer connected with the military services.

Dr. Daniel L. Borden, Past President of the Medical Society of the District of Columbia, when discharged held the rank of Colonel in the Medical Corps of the United States Army. His most recent tour of duty was for $3\frac{1}{2}$ years. Following his term of office as the Society's President, Dr. Borden became Chief Surgeon at Fort Meade, Maryland, with the commission of Lt. Colonel. Later he was transferred to Fort Eustis, Virginia, where he was Commanding Officer of the Station Hospital. While there he was promoted to the rank of Colonel. Dr. Borden's last assignment was to the Third Service Command, with offices at Baltimore. As many physicians here know, Dr. Borden served with the military forces in three wars.

Dr. Mazarin C. Dollman, Lt. Colonel in the Army Medical Corps, was ordered to duty February 16, 1941. He proceeded to Fitzsimons General Hospital, Denver, Colorado, where he established an Enlisted Medical Technicians School. A year and a half later he was transferred to the Port of Embarkation, San Francisco, California, where he became Post Surgeon at Fort McDowell, Angel Island, California. Dr. Dollman was placed on inactive status December 4, 1944, due to physical

disability. His military service covers a period of more than a quarter of a century, he having served in the Mexican Border Campaign and World War I, in the latter instance as Commanding Officer of the 72nd General Hospital with the American Expeditionary Forces at Meves, France.

Dr. William C. Meloy, who was discharged from the Navy some months ago with the rank of Lt. Commander, has resumed his practice at 2019 R Street, N.W. Dr. Meloy was commissioned an officer in the United States Navy early in 1942. He served on the *U.S.S. Pinckney* and participated in the battle of the Solomons, distinguishing himself under fire. He also took part in the initial assault on Bougainville.

Dr. Francis C. Allman entered the United States Navy as Lieutenant. He did X-ray work during his entire period of service. His first assignment was to the Naval Hospital in Pensacola, Florida. He was later transferred to an Advanced Naval Base where he stayed until injured. He was discharged January 5, 1945.

Dr. Eugene W. Higgins returned to civilian practice in January. He was commissioned Lieutenant (s.g.), U.S.N.R., when he entered the service in September of 1942. He was stationed at the Blood Plasma Unit of the American Red Cross Donor Center in Washington. He helped design and was in Washington for the opening of the new Center in the Acacia Building in July of 1943. In August he went to Harrisburg, Pennsylvania, where he was assigned to duty at the Blood Donor Center. His next tour of duty was with the Amphibious Forces

in Norfolk where he served from May 1944 until his discharge February 23, 1945.

Dr. George Dewey was commissioned Lt. Colonel, and served as Chief, Consultant Section, 20th Hq. Medical Service, C. Z. Desert Training Center, and as Chief, Medical Service, Camp Butner, North Carolina. He was discharged on April 9, 1945, because of physical disability.

Dr. Stewart M. Grayson, serving as Regimental Surgeon of the 260th Coast Artillery Anti-Aircraft Regiment in the District of Columbia National Guard, entered Army service with the above Regiment on January 6, 1940. On January 13, 1940, he left for El Paso, Texas, where he remained until the day after Pearl Harbor. He was then made Surgeon of the 39th Brigade and stationed near Seattle, Washington, where he served until June 15, 1942, at which time he was retired because of disability with the rank of Lt. Colonel. He is now teaching at George Washington University. Dr. Grayson spent 22 months overseas in World War I with the 3d Division, 8th Machine Gun Battalion. He served in the Army of Occupation in Germany for nine months. He was awarded the Silver Star and the Distinguished Service Cross.

Dr. Arthur Nachlas, commissioned Lieutenant in the Army Medical Corps, was stationed at the 13th Field Hospital, Camp Bowie, Texas, from August 1, 1942 until December 1942, when he was discharged because of physical disability.

Dr. Murry W. Robinson served with the Army as Captain from November 15, 1940, until October 27, 1943. For a short time he was on detached service in Canada.

Dr. Saul Schwartzbach was Lt. Commander in the United States Navy from March 1942 to April 1943. During this period he was stationed at Washington, D. C., Panama, the Galapagos Islands, and Norfolk, Virginia.

Dr. Joseph W. Stein entered the Army April 20, 1942, as a Lieutenant, being first assigned to Ft. Meade, Maryland, where he was stationed until October 1, 1942. He was then transferred to Camp Pickett where he served until his discharge on September 26, 1943.

Dr. Philip O. Pelland served with the Army for two years from June 1942 to May 27, 1944, when he was discharged with the rank of Lt. Colonel. He was first assigned to Lawson General Hospital,

Atlanta, Georgia, with the rank of Major. Other assignments included staff appointments at McCloskey General Hospital, Temple, Texas, and Station Hospital, Camp Livingston, Louisiana. Dr. Pelland has returned to his orthopedic practice in Washington.

Dr. Harry M. Fletcher returned to civilian practice more than a year ago. He was commissioned Captain in the Medical Corps of the United States Army, being first assigned to Miami Beach, Florida, after which he served successively at the Station Hospital, Atlantic City, New Jersey; Station Hospital, McDill Field, Tampa, Florida; Station Hospital, Drew Field, Florida; Battey General Hospital, Rome, Georgia; and Camp Croft, South Carolina.

Other members or former members of the Society who have been on active military duty and have now returned to civilian life are Drs. Edward A. Krause and Francis N. McDonald.

CORRESPONDENCE

WASHINGTON, D. C., July 11, 1945

DR. WALLACE M. YATER

EDITOR, MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA
WASHINGTON, D. C.

Dr. Yater, our gratitude seems small-fry!

It's inadequate for the generosity, for the patriotism, for the effectiveness of publishers' coöperation during the 7th War Loan.

In our Washington offices, you can see for yourself the colorful and ingenious War Bond covers that are displayed, not by tens or scores or hundreds, but by the thousands: covering walls from floor to ceiling.

AND THAT'S NOT ALL—editorials, full-page ads, cartoons, and feature articles are all massed together in a demonstration of forceful influence unmatched in any previous campaign, public or private.

That's why our simple words of appreciation for your vital war effort support don't measure up to the Treasury's pleasant wish—to tell you how grateful we are. But your magnificent war financing contribution has other rewards: It's a helping hand for the care of our wounded, a strong blow to down any threat of inflation, a kind friend to fulfil hopes for education, homes, security.

Cordially yours,

ELIHU E. HARRIS

Chief, Periodicals Section, War Finance
Division, Treasury Department

On The Home Front

The Department of Legal Medicine of the medical schools of Harvard, Tufts, and Boston University, in association with the Massachusetts Medico-Legal Society, will present a six-day program of lectures, conferences, and demonstrations having to do with the investigation of deaths in the interests of public safety. Attendance is limited to 15 persons who must register in advance. Further information may be obtained from the Secretary of the Massachusetts Medico-Legal Society, 25 Shattuck Street, Boston.

Among the interesting publications which have reached the Society's office is a recent copy of the *Journal of the Royal United Service Institution*, London. The issue (May 1945) contains the address on "Morale at Sea" by Commodore Arthur W. Clarke, D.S.O., R.N., which was delivered at the 16th ANNUAL SCIENTIFIC ASSEMBLY of the Medical Society of the District of Columbia, October 5, 1944, and which was originally published in the *MEDICAL ANNALS* for November, 1944.

The *R.U.S.I. Journal* is the official organ of the Royal United Service Institution, of which His Majesty King George VI is Patron and The Duke of Gloucester, President. It is published quarterly "for the promotion and advancement of the science and literature of the three services" under the direction of a Council which consists of a large number of high ranking officers of the Navy, Army, Marines and Air Force.

The Executive Board, at its meeting, June 25, voted to accept from Miss Edith Cockerille of Washington a gum lancet used in the latter part of the 18th century by Dr. John T. Swann, practicing physician in Powhatan County, Virginia. The lancet has been placed on display in the exhibit case in the library.

Two staff members of Gallinger Municipal Hospital have recently severed their connections with that institution. Dr. Frederick G. Gillick, head of the Venereal Disease Bureau of the District

CALENDAR OF MEETINGS

June 4	Executive Board
June 21	Section on Pediatrics
June 25	Executive Board
July 5	Scientific Meeting of Society
July 9	Executive Board
July 10	Executive Board
	Medical Bureau Committee
	Subcommittee on Prepaid Medicine
July 17	Committee on Industrial Medicine
July 19	Subcommittee on Prepaid Medicine
July 23	Executive Board
July 24	Committee on Industrial Medicine
July 26	Section on Neurology and Psychiatry
July 27	Committee on Public Health
July 28	Section on Pathology and Laboratory Medicine

Health Department and founder of the Rapid Treatment Center at Gallinger Hospital, left July 31. He will devote his full time in the future to research and teaching with the United States Public Health Service. Dr. Gillick, who was given leave from the U.S.P.H.S. in 1942 to assist the District in controlling the spread of venereal disease, became Chief of the Bureau in April, 1943. He opened the Rapid Treatment Center at Gallinger almost two years ago, and supervised venereal disease clinics at the Southwest Health Center, Polk School and Freedmen's Hospital.

The resignation of John F. Barker, Deputy Superintendent of Gallinger Hospital, became effective August 15. He will become Executive Director of the Vicksburg (Miss.) Hospital. Mr. Barker came to the District last year from Hampton, Va., where he supervised the Dixie Hospital.

Dr. Michael M. Miller, psychiatrist at St. Elizabeths Hospital, opened the District's first clinic for alcoholics, August 6, in the Municipal Center, with sessions being held twice weekly. The clinic will be conducted as a part of the Mental Hygiene Bureau. Dr. Ruth Stocking, of the

Children's Bureau, is assisting Dr. Miller with medical examinations.

The cornerstone of the new **graduate nurses' building** at **Catholic University** was laid July 6 by the Right Rev. Msgr. Patrick J. McCormick, Rector of the University. The building, which will be constructed of brick at a cost of \$240,000, will provide dormitory space for 100 students of the School of Nursing Education in addition to lounge, conference rooms, dietetic laboratory and cafeterias. A substantial portion of the cost of the building, \$156,000, was allotted by the Federal Government under legislation which provides a fund for training of nurses for the armed forces and public health service. Plans provide for the completion of the structure this fall.

The **Washington Society for the Hard of Hearing** has announced the appointment of Miss Rose V. Feilbach as Executive Secretary of the Society. Miss Feilbach has had seven years of experience in the field of the hard of hearing, having been Executive Secretary of the Portland (Oregon) Society for the Hard of Hearing for the past two years. Previous to that time, 1938 to 1943, she was head of the special education department at the library of Union City, New Jersey. The District Society for the Hard of Hearing is planning to coördinate its social work more fully with that of other social agencies and resources.

The following physicians have been elected officers of the medical staff of **Prince Georges General Hospital**, Cheverly, Md.: Dr. Waldo B. Meyers of Mt. Rainier, *President*; Dr. Aaron Deitz, Hyattsville, *Vice President*; Dr. James G. Sasscer, Upper Marlboro, *Secretary*. Drs. Oscar Lavine and Robert McCeney were elected to membership on the Executive Committee.

The new **Finance Subcommittee of the Executive Board** met preceding the regular Board meeting, July 23. Members are Dr. William P. Herbst, *Chairman*; Dr. A. Magruder MacDonald and Theodore Wiprud.

Medical officers who have called at the Medical Society's offices recently are **Lt. Comdr. Morris I. Bierman**, who has been on sea duty in the Pacific

for most of the three years he has been with the Navy, and **Major Francis T. Coleman**. Major Coleman was on overseas duty until two years ago; since then he has held hospital assignments at Maxwell Field, Alabama, and Tyndall Field, Panama City, Florida.

BOOK REVIEWS

Rypins' Medical Licensure Examinations; Topical Summaries, Questions, and Answers, 5th ed., edited by WALTER L. BIERRING, M.D., F.A.C.P., M.R.C.P., Edin. (Hon.); Member, National Board of Medical Examiners; Secretary, Federation of State Medical Boards of the United States, WITH THE COLLABORATION OF A REVIEW PANEL. Price, \$6.00. Pp. 546. Philadelphia: Lippincott, 1945.

This new edition of Rypins' text on Medical Licensure Examinations has been completely revised under the editorial direction of Dr. Walter L. Bierring, in collaboration with a review panel of outstanding teachers and clinicians. A new section on Pharmacology has been added. The book should prove valuable to examiner and examinee inasmuch as it presents typical state board examination questions and answers or discussion of the subject.

Apart from the interest and value which the book presents, one cannot help but contemplate the absurdity of the maintenance of separate state boards. Knowledge of the human body and the ills it falls heir to, manifestly is not qualified by political jurisdiction. Anatomy, physiology and pathology are the same in one part of the country as in another. Treatment, likewise, follows more or less the standard prevailing practice as taught in the medical schools of the country.

One hopes that the day may come when a single examining board, patterned after the National Board, may receive national recognition so that those who passed the examination of such board will be entitled to practice medicine anywhere in the United States.

G. C. R.

Technical Methods for the Technician, 3rd ed. ANSON L. BROWN, A.B., M.D., Director of Dr. Brown's Clinical Laboratory and Dr. Brown's School for Technicians, Columbus, Ohio. Price, \$10.00. Pp. 706. Columbus, Ohio: A. L. Brown, 1944.

The reviewer is very favorably impressed by the general plan of the book and particularly likes the introductory chapters on Laboratory Behavior; The Microscope; and Simple Laboratory Operations. Unfortunately, in the copy at hand, a number of pages are not

in their correct order. It is hoped this may be an error peculiar to this and not present in the other copies of this edition.

Doubtless any reviewer will disagree with some details in any volume of this sort. Some will be slightly irritated by the use of such terms as "a urine" or "a blood" or "a false positive sugar will result." I personally would prefer to refer to a "sample" or "specimen" of blood or urine and to a "false positive reaction or test for sugar." These are perhaps of minor importance and yet it would seem helpful to teach our students correct rather than colloquial usage in these matters.

There is a tendency to dismiss some findings as having no significance, when, as a matter of fact, they may serve as "leads" in the evaluation of a sample submitted, as, for instance, "a urine with the odor of ammonia is spoiled." The statement that "there is relatively little significance to the odor of any urine specimen" is contradicted by the sentences following indicating a definite significance of certain odors which are described and interpreted. These points are all relative to page 58. On page 61: "There is actually very little significance to a specific gravity. However, if the specific gravity is high, for example 1.030, sugar may be present. On the other hand, if the gravity is low, e.g. 1.005, albumen may be present." This is, in my opinion, incomplete and contradictory. On pages 77 and 78, under the test for d-acetic acid it is stated that a "red coloration denotes d-acetic acid." This, of course, is true only if the test be performed with proper controls and interpreted in connection with the clinical data, particularly as to the taking of drugs. I do not agree with the rule that "we never test for diacetic acid and acetone except in those urines which show a positive sugar." The statements regarding the normal levels of blood sugar and the "sugar threshold" on page 221 are, in my opinion, erroneous and dangerous. The test for phosphatase in the blood does not consider the acid and alkaline phosphatases which are now considered essential.

The section on feces is so sketchy that it would be better to omit it.

It is a disappointment to note that the Rh factor, one of the most important subjects in medicine, and one of the laboratory's most important procedures, is not mentioned.

I am not impressed with the idea of reporting microscopic findings in the urine in "millions."

The reference to the principal causes for albumen in the urine is quite unsatisfactory.

I regret that I feel compelled to cite these criticisms in a book with some excellent features, but it would be necessary, in our own school, to make many marginal notes before placing it in the hands of our students.

Granting its general usefulness, this imposes an unwarranted task of revision upon the purchaser which should have been assumed by the author and publisher in the course of three editions.

By way of apology for my observations, I will place an annotated copy of this volume in our laboratory, hoping that the next edition will correspond in correctness and "polish" with the qualities I am able to endorse.

J. W. L.

The Management of Neurosyphilis. BERNHARD DATNER, M.C., J.R. D., Associate Clinical Professor of Neurology, New York University Medical College, with the collaboration of EVAN W. THOMAS, M.D., Assistant Professor of Medicine and Assistant Professor of Dermatology and Syphilology, New York University Medical College, AND GERTRUDE WEXLER, M.D., Instructor in Dermatology and Syphilology, New York University Medical College. Price, \$5.50. Pp. 398. New York: Grune & Stratton, 1944.

Dr. Dattner came to the United States in 1938. Prior to this he had worked with Wagner-Jauregg in Germany and published a monograph on neurosyphilis. The present book, written in collaboration with Thomas and Wexler, is an entirely new work combining the fruits of American and European experience. The writers review much of the world literature on the subject, prudently paying particular attention to Moore's "Modern Treatment of Syphilis."

The first part of the book emphasizes the value of the spinal fluid changes in diagnosing neurosyphilis rather than the clinical objective signs. Also, the same method is suggested in evaluating the therapeutic response.

The second part of the book is devoted to therapeutics. The author believes that, at some time or other, some form of hyperpyrexia should be employed in all cases of neurosyphilis in addition to all other types of therapy that might have been used. Therapeutic malaria is advised as the method of choice. This conclusion is logical since the author worked in the clinic of Wagner-Jauregg, the father of therapeutic malaria.

It is believed that this book is the outstanding reference for the syphilologist or other physician who is called upon to treat this complex disease.

G. W. C.

Control of Pain in Childbirth. CLIFFORD B. LULL, M.D., F.A.C.S., Clinical Professor of Obstetrics, Jefferson Medical College; Assistant Director, Philadelphia Lying-In Unit, Pennsylvania Hospital, AND ROBERT A. HINGSON, M.D., Surgeon, U. S. Public Health Service; Director, Postgraduate Medical Course, Phil-

adelphia Lying-In Unit, Pennsylvania Hospital. Price, \$7.50. Pp. 341, with 132 illustrations. Philadelphia: Lippincott, 1944.

This is a volume of slightly over three hundred pages containing a rather detailed review of the various and sundry anesthetic and amnesic agents in use now and the very recent past.

Obstetrical anesthesia, both local and general, is ably presented and without bias. Each drug, with its advantages and disadvantages, is discussed and its effects illustrated by means of diagrams.

The anatomy of the nerve supply of the local organs participating in labor, with the physiology thereof, is shown in detail as is the anatomy of the spinal column, with particular emphasis on the sacrum and its many anomalies.

That portion of the book concerning pain relief in the usual abnormalities seen at labor, such as eclampsia, intercurrent disease, etc., is especially good.

One cannot read this volume without feeling that the authors have an enthusiasm and preference for continuous caudal and wish to call the attention of the profession to this method.

Two statements of particular interest are quoted below:

"The most important part in the practice of good obstetrics is that each patient should be individualized, particularly as regards pain relief. . . ."

"Of primary importance in the control of pain is the recognition of it as a psychologic entity. . . ."

For the general practitioner who includes obstetrics in his work, this book will be valuable for its mass of information, while the specialist in that field will find it most worth while if for no other reason that for its ease of reference.

G. N.

REPRINTS RECEIVED

The following reprints have recently been received, for which due acknowledgment is made:

"Catheter Incontinence Following Cystoscopy." Norvell Belt. *Journal of the American Medical Association*, August 12, 1944.

"Heart Disease; an Elementary Reference for Physicians." Robert S. Berghoff. Illinois Department of Public Health, Circular No. 176, January 1944.

"Postwar Industrial Health." Wm. R. Bradley. *Chemical and Engineering News*, December 1944.

"Institutional Facilities for the Treatment of Alcoholism." E. H. L. Corwin and Elizabeth V. Cunningham. *Quarterly Journal of Studies on Alcohol*, June 1944.

"Transmesenteric Hernia." George D. Cutler and H. William Scott, Jr. *Surgery, Gynecology and Obstetrics*, November 1944.

"Suggested Inquiry into Possible Relation between Albuminuria, Essential Hypertension and Nutritional Deficiency." William DeKleine. *Journal of the Michigan State Medical Society*, October 1944.

"Research Is Key to Connecticut System of Cancer Control." Matthew H. Griswold. *Hospitals*, August 1944.

"Annular Pancreas Producing Duodenal Obstruction; Report of a Successfully Treated Case." Robert E. Gross and Tague C. Chisholm. *Annals of Surgery*, May 1944.

"The Control of Yellow Fever." M. V. Hargett. *Puerto Rico Journal of Public Health and Tropical Medicine*, September 1944.

"Correlation of the Purity of Penicillin Sodium with Intramuscular Irritation in Man." Robert P. Herwick, Henry Welch, Lawrence E. Putnam and Armand M. Gamboa. *Journal of the American Medical Association*, January 13, 1945.

"Endocrinology; a Brief Review for Physicians." James H. Hutton. Illinois Department of Public Health, Circular No. 177, January 1944.

"Clinical Use of Products of Human Plasma Fractionation. III. The Use of Products of Fibrinogen and Thrombin in Surgery." Franc D. Ingraham and Orville T. Bailey. *Journal of the American Medical Association*, November 11, 1944.

"Studies on Fibrin Foam as a Hemostatic Agent in Neurosurgery, with Special Reference to Its Comparison with Muscle." Franc D. Ingraham, Orville T. Bailey and Frank E. Nulsen. *Journal of Neurosurgery*, May 1944.

"Cerebeller Medulloblastoma with Verification Nineteen Years After the Onset of Symptoms." Franc D. Ingraham and Orville T. Bailey. *Journal of Neurosurgery*, July 1944.

"The Surgical Treatment of Esophageal Atresia and Tracheoesophageal Fistulas." William E. Ladd. *New England Journal of Medicine*, May 25, 1944.

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"The Social Dynamics of the Physician's Status." Alfred McClung Lee. *Psychiatry: Journal of the Biology and Pathology of Interpersonal Relations*, November 1944.

"Public Relations Survey of California." John R. Little. *California and Western Medicine*, July 1944.

"Postwar Planning: Results of Pilot Questionnaire to Physicians in Service." Harold C. Lueth. *Journal of the American Medical Association*, June 24, 1944.

"Our Concern—Every Child. State and Community Planning for Wartime and Post-War Security of Children." Bureau Publication 303, U. S. Government Printing Office, 1944.

"Survival Rates of Individuals Who Have Had Proved Cancer in Connecticut—1935-1942." Eleanor J. MacDonald. *Connecticut Health Bulletin*, November 1944.

"Treatment of Gonorrhea and Studies of Intramuscular Irritation with Seven Salts of Penicillin." Lawrence E. Putnam, Henry Welch and Sidney Olansky. *Journal of the American Medical Association*, January 27, 1945.

"Evaluation of a Sick Report System." Leon Schwartz. *Personnel Administration*, June 1944.

"County Medical Society Life Memberships and Endowment Funds." Harold Swanberg. *Mississippi Valley Medical Journal*, July 1944.

"Malpractice and X-rays." Harold Swanberg. *Mississippi Valley Medical Society*, January 1944.

"Chorea Syphilitica; Report of Two Cases." George D. Weickhardt. *Urologic and Cutaneous Review*, January 1945.

"Penicillin X; Successful Treatment of Gonorrhea with a Single Intramuscular Injection." Henry Welch, Lawrence E. Putnam, William A. Randall and Robert P. Herwick. *Journal of the American Medical Association*, December 16, 1944.

"Enrichment of Flour and Bread; a History of the Movement." Russell M. Wilder and Robert R. Williams. *Bulletin of the National Research Council*, November 1944.

"Epilepsy—The Ghost Is Out of the Closet." Herbert Yahraes. *Public Affairs Pamphlet No. 98*, 1944.

"Report of a Case of Teratoma of the Liver in an Infant." Silas M. Yarbrough. *Texas State Journal of Medicine*, December 1944.

LUTHER HALSEY REICHELDERFER, M.D. (1874–1945)

One of Washington's most distinguished physicians, Dr. Luther H. Reichelderfer, died suddenly at his home, 1661 Crescent Place, N.W., from a heart ailment, on June 19, 1945.

Dr. Reichelderfer was not only a successful physician, but had made a fine record as a public official. He was President of the Medical Society of the District of Columbia in 1913, and has been a Life Member since 1941.

Born in Hallsville, Ohio, on February 4, 1874, he came to Washington at the age of three. He attended Franklin School and Central High School, from which he graduated in 1892. He was a colonel in the school cadet corps. Shortly after his graduation he joined the faculty of the Business High School, now Roosevelt High School, meanwhile studying medicine at Columbian (now George Washington) University School of Medicine. He received his degree of Doctor of Medicine in 1899 with class honors.

Dr. Reichelderfer interned at Garfield Hospital from 1899 to 1900 and was Chief Resident from 1900 to 1907. Later he was attached to the surgical staffs of Garfield, Children's and Tuberculosis Hospitals. He remained on these staffs until his retirement in 1924. From 1900 to 1924 he was a member

of the faculty of George Washington University School of Medicine.

Dr. Reichelderfer also had a notable military career, having served for 23 years with the District National Guard. He entered the National Guard as a Lieutenant and advanced to the rank of Lt. Colonel and Chief Surgeon. During World War I he served with the American Expeditionary Forces



LUTHER H. REICHELDERFER, M. D.

in France as Lt. Colonel in the Medical Corps, at the end of the conflict receiving his commission as Colonel.

In 1930 President Herbert Hoover appointed Dr. Reichelderfer District Commissioner. He was inducted into this office on April 10, 1930. Elected President of the Board of Commissioners, he served until November 16, 1933.

Dr. Reichelderfer was a Fellow of the American College of Surgeons and of the American Medical Association, a member of the Hippocrates-Galen Medical Society, the Clinico-Pathological Society, the Association of Military Surgeons of the United

States, the University Club, and the Washington Board of Trade. He was also active in the District Welfare and Recreation Association, including the Boys' Club of Washington.

A quiet, kindly, thoughtful man, Dr. Reichelderfer had many friends. They respected his judgment both as a physician and a civic leader.

Dr. Reichelderfer is survived by his wife, the former Mary McCauley, whom he married in 1903.

EDWIN KIRBY SMITH, M.D.

(1899-1945)

Although still a comparatively young man, Dr. Edwin Kirby Smith, an Active Member of the Medical Society of the District of Columbia, died at his home at McMinnville, Tennessee, on June 22, 1945. The biographical data with respect to Kirby, as he was known to his Washington colleagues, can be briefly stated. Born in Mt. Vernon, Illinois, March 15, 1899, he was a graduate of George Washington University School of Medicine, from which he received his Doctor of Medicine degree in 1927. Following internships at Garfield and Children's Hospital of Washington and Cincinnati Children's Hospital, he entered practice in Washington, limiting himself to pediatrics. For a number of years he was on the staff of Children's Hospital, Washington. However, illness forced him to give up his practice in 1937. Shortly thereafter he moved to McMinnville in the hope of regaining his health.

These simple facts, however, do not do justice to one of the most promising and colorful physicians in Washington's medical history. He was a dynamic and tireless worker, and deeply concerned with the welfare of his profession. Those who knew him not only held him in great esteem but deep affection.

It is a privilege for me to record my deep attachment for Kirby although I met him personally on only two or three occasions. I saw him first in November 1937 and was at once impressed by his attractive personality and his qualities of leadership. Shortly thereafter he became ill, but his letters to me were always cheerful. He apparently thought up to the last that he would return to Washington, but that was not to be.

Kirby's sense of humor never failed him.

Some months ago he was sent a form by the Medical Society on which to state his specialty and provide pertinent data. He returned it with many humorous allusions to his situation, referring to himself as the "Squire of Shellsford," his home address being "Hardacres," his office hours, "When you can catch me," and his specialty, "Skin and contents." He never lost his sense of humor.

He carried on some practice in McMinnville where, as might be expected, he was highly thought of. McMinnville's *Southern Standard* had this to say about him:

"Dr. Smith possessed a very brilliant mind and this together with his friendly and jovial disposition and personality resulted in the formation of many close friendships in his adopted town . . . and the surrounding section. The news of his sudden death rapidly spread in our town and brought profound sorrow among his many close friends and associates."

Those of us who were privileged to know this fine physician and gentleman will always remember him.

He is survived by his wife, Bernice Brennan Smith, a daughter, Nancy Lee Smith, and a son, E. Kirby Smith III.

THEODORE WIPRUD

JOHN CAMERON McCLUER, M.D.

(1906-1945)

Dr. John Cameron McCluer, of 605 Jefferson Street, Alexandria, Virginia, an Associate Member of the Medical Society of the District of Columbia, died June 26 at Garfield Hospital after a long illness.

Dr. McCluer was born in Parkersburg, West Virginia, May 11, 1906. He graduated from Peabody High School, Pittsburgh, and from the University of Virginia Medical School in 1932. He came to Alexandria in 1933 after serving his internship at DePaul Hospital in St. Louis, Missouri, and Camden-Clarke Hospital in Parkersburg. In the summers of 1940 and 1941 he did graduate work in cardiology at the Massachusetts General Hospital under Dr. Paul White.

During his 11 years of practice in Alexandria, Dr. McCluer was very active in the health and welfare activities of the community. He served on the Alexandria Board of Health for five years and was President for two years. He was a member of the

Board of Directors of the Alexandria Community Chest, the Alexandria Community Health Center, the Alexandria Tuberculosis Association, and was a charter member of the Alexandria Council of Social Agencies. He was Past President of both the Alexandria Medical Society and the Alexandria Hospital Medical Staff.

Surviving are his mother, Mrs. Annie Laurie McKinney McCluer, of 409 Green Street, Alexandria, and one sister, Miss Betty Bell McCluer, now serving as a secretary with the Army Air Forces in Calcutta, India. His father, John C. McCluer of Parkersburg, preceded him in death.

Physical Medicine—Piersol

(Continued from page 350)

to time come under observation. Their management consists of the intelligent use of the various technics, alone or in combination, that have been discussed. An effort has been made to point out the procedures in physical medicine that are generally accepted as being of the most value in the management of the type of patients most often seen in the general hospital or in private practice.

As aptly put by Scull,⁶ "The nucleus of physical therapy as a whole is a quartette of rest, heat, massage and exercise, and to these nothing has been added since the days of the ancients except irradiation involving roentgen rays and radium." "Laying on of hands" unfortunately has fallen into the wrong hands in many instances but the renaissance now taking place in physical therapy promises that this oldest of the healing arts will again come into its own."

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Intraperitoneal Sulfanilamide—Cox and Forrest

(Continued from page 355)

active under anaerobic conditions.¹⁰ Probably the real clue to the failure of sulfanilamide to materially aid in the treatment of peritonitis is the now well established fact that sulfanilamide is inactivated in the presence of pus.^{1,12}

It is useless to dwell upon the disadvantages and dangers of the intraperitoneal use of sulfanilamide except to say that they exist. Toxic effects may be expected to range from slight cyanosis to anemia, leukopenia and hepatitis.¹³

CONCLUSIONS

1. Equally good and in some cases better results have been obtained in the treatment of perforative appendicitis without the use of sulfanilamide as compared with groups of cases treated with sulfanilamide intraperitoneally.

2. Sulfanilamide is known to be ineffective against the majority of organisms obtained from cultures of the peritoneal exudate of cases of perforative appendicitis, especially in the presence of a purulent exudate.

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Future of Medicine—Lawrence

(Continued from page 359)

physicians had discussed the problems incident to such a plan with groups of legislators and with the Governor on frequent occasions during the year until everybody thoroughly understood what was sought. The newspapers were in on all of the conferences and kept the public informed of the progress being made. Officials of the newspapers manifested their appreciation of the opportunity they were accorded to keep the public informed by entertaining the president, the president-elect and the secretary of that society at a dinner to which the Governor came.

In addressing you thus, I am fully cognizant of the splendid programs your Society has developed and the gratifying success you have had in your public relations activities. My comments are my own thoughts, springing from my observations and conversations in the Capital and over the states.

Praise for the Medical Division

(Continued from page 375)

On behalf of the District of Columbia War Finance Committee, I thank you for doing a war finance job about which you all may well be proud. It is reassuring for us who face the war finance job that lies ahead to know that we will have such staunch associates as you and the members of your committee working with us side by side.

Sincerely yours,

W. J. WALLER

Chairman, D.C. War Finance Committee

Socialized Medicine

(Continued from page 382)

questions. Voluntary efforts are presently getting into their real stride. They have not proved to be a drag on the country's high quality of medical proficiency or the brilliant progress made in research. By expanding and improving our public health service, by supporting various group and community systems, and by encouraging private insurance companies to add to the usefulness of their services, the country should find that Federal control of medicine is not necessary to insure a healthy nation. Historically the experience of foreign countries provides no evidence to the contrary.

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THE STORY OF PENICILLIN*

SIR ALEXANDER FLEMING

London, England

I AM to talk to you about the discovery of penicillin and its development as a therapeutic agent. It seems a pity to me sometimes that I ever got mixed up with penicillin. I have been accused of inventing it but it would be very difficult for any man to invent penicillin, since a mold has been making this substance for thousands of years although we didn't know anything about it. All I did was to bring it to the notice of the medical profession, to find out some things about it, and, incidentally, to christen it.

It is also said that penicillin was found by accident. That all depends on the definition. When I first noticed the action of penicillin I was playing with a culture of staphylococcus, doing nothing very important. Actually, what had happened was that I had contracted to write the chapter of a book on staphylococcus. A man had written, saying that by certain methods he could make the colonies of staphylococcus appear not a bit like what they should. I was trying to see whether he was telling the truth or not. I had some culture plates of

staphylococcus, looked at them occasionally under a microscope, put the cover back on, and set them aside for a while.

When some people are finished with a culture plate they chuck it away, and that is the end of it. Of course, they miss a lot of peculiar things that happen by accident. But I didn't throw those away, and later on they were contaminated. Of course, if you take off the cover of a culture plate you get things in from the air. One of the plates got contaminated with a mold. That wasn't so unusual. We had often had plates contaminated with molds before and hadn't paid much attention to them except to use appropriate language and chuck them away.

But this time there was something different on the plate. The mold itself wasn't a bit unusual, but what happened was unusual. The microbes in the neighborhood of that mold colony seemed to be dissolving. That was worth paying attention to. At least, I thought it was, and I didn't pursue the original staphylococcal research.

I touched that mold with a platinum wire and transferred some of the spores to another tube off by themselves, and there we had a pure

*An edited, stenographic report of an address delivered before the Society, July 5, 1945.

culture of the mold that we could keep and experiment with.

I don't know whether you really know much about molds. I knew nothing at all at that stage of the proceedings. A mold starts off with a little spore, a tiny little thing, smaller than a red blood corpuscle, and then when it grows it sends out a sprout or two, and then they branch, branch again, and branch again, and you finish up with the mass of mold that you recognize on bread or cheese or whatever it is. It starts off being white, and then it sends up spikes into the air. With the *Penicillium*, the mold that we are concerned with, you have a mycelium down below, and it sends up special reproductive hyphae. These have a number of short stumpy branches each of which sends out still shorter branches from the ends of which spores are budded off. The whole thing resembles under the microscope a pencil or brush—hence the name *penicillium*. Those spores float about in the air. Some of them had dropped down on this culture plate.

Then we tried to see what this mold did. One of the first things we did, an easy one, was to put it on another culture plate. You take a fresh culture plate, plant the mold, and let it grow in the room. You don't want an incubator for this. This room would do beautifully for mold. Just let it grow for 3 or 4 days. Then we took different microbes, whatever was handy, and streaked them across the plate up to the mold. Some of them grew right up to the mold; some of them didn't go anywhere near. So, then we had a mold which made something which diffused out into the agar and which stopped the growth of some of the microbes but not others. We had seen this sort of thing before. It was about 5 or 6 years before this that I had shown exactly the same thing, not with a mold that time, but with human tears. We had taken human tears and put them on an agar plate and streaked microbes up to them. Some of them would be inhibited in the same way. With sputum or egg white it was just the same.

The only trouble about the tears was that the microbes which were inhibited most were not the ones that infect man. So, that was not so important as a medicinal agent, but the microbes which were inhibited by the mold were the common microbes that infect man, the staphylococcus, the streptococcus, the gonococcus, and that type of microbe, which made it more interesting.

The next thing was to grow it on a fluid medium. Being bacteriologists, the first fluid medium handy to grow our microbes on was broth. We put some mold spores on top of that. The mold grew to a fluffy mass on the top of the fluid, the fluid becoming yellow underneath. Incidentally, some have talked about yellow magic and things of that kind. The yellow color has nothing whatever to do with the activity. It is an impurity. But it does give a nice yellow culture.

Then we had to test whether or not the antiseptic substance was in the fluid or whether it was contained in the mold substance, the actual growth. That was very simple again. We took another culture plate and with a knife made 2 cuts. With a dipper we dipped out some of the jelly, the agar, and then filled it up again with fresh agar containing the culture fluid.

Up to then it had not been christened. Its favorite name in my notebook was "mold juice," but about this time we began to call it penicillin. We called it penicillin because it came from a *Penicillium*.

We streaked microbes up to this juice the same as we did to the mold, with exactly the same result. Some microbes grew right up to the culture fluid; others didn't go anywhere near it. That showed that the mold made something which appeared in the culture fluid which diffused in the agar and affected many of the common microbes. It stopped the growth of many of the common microbes which infect man.

You see, the fluid is very diffusible in agar.

I think that is an important test. It is interesting to compare its diffusibility with some of the old-fashioned antiseptics. What we did was to take an agar plate and punch out holes. In each one of those holes we put bits of filter paper soaked in the particular antiseptic, 1 per cent iodine, 1 to 20 carbolic acid, and so forth. In one hole the filter paper was soaked with the fluid as it came from the mold culture. Then those holes were filled up with agar so as to anchor the antiseptic and it wouldn't affect any microbes planted on the surface until it diffused through perhaps an eighth of an inch of agar. We planted the staphylococcus on top of that, and the staphylococcus grew over the top of the old-fashioned antiseptics but wouldn't go near the penicillin. All chemicals that have been useful antibacterial agents in the body do diffuse well in agar. It is a very simple test and I think one that might be used more.

We had got this far. We had a substance made by the mold which affected some microbes and not others. It was diffusible. We had to test its strength. That test is just the orthodox dilution method. We found that with a good culture you could dilute up to perhaps 1,000 and still stop the growth of microbes. That may mean nothing to some of you, but if you dilute carbolic to 1 in 300 it just inhibits growth; if you dilute it to 1 in 400 it doesn't inhibit growth. So, we had here something that we could dilute a good deal more than carbolic acid, and yet it stopped the growth of microbes. That was another interesting thing.

Then we had to see whether it was poisonous, like the other antiseptics. We injected some into animals. It was just as poisonous as the broth in which it was grown. A thing that had interested me for years was the relative toxicity of chemical antiseptics to microbes and to blood cells. So we also tested it on blood cells. There are many tests, but we used a simple test that I like, and I should like to see people adopt it more. You take some blood, human blood.

It is good to work with human blood. In most cases you get far more information out of human blood than you get out of animal blood, and also you always have 5 fingers that you can prick and can get blood from at any moment. It is a lot easier and gives you much more information, but there are some who will go to rabbits and guinea pigs, and they don't get the proper results at all.

Take some human blood and mix it up with a chemical, any chemical you like, and a suitable number of microbes. Suppose you take human blood infected with a reasonable number of staphylococci. The blood will kill 95 per cent or more of those. It kills them by virtue of the leukocytes, but if you take the leukocytes away it has no killing power. So, you have the blood killing off most of the staphylococci.

You put into that blood a staphylococcus mixture and add carbolic acid in a concentration of 1 in 600. We put, say, 50 staphylococci in there with the blood by itself, and you get about 2. Now we put carbolic acid in there in a concentration of 1 in 1,200 and we get 10 or a dozen, a bit more than we get without the carbolic. With the 1 in 600, out of 50 microbes, 50 will grow. What has happened there is that the chemical has killed all the blood cells and let the microbes grow. That happened with all the antiseptics. I took carbolic acid as an example, but it doesn't matter which of the old antiseptics you use, it has that effect.

When we came to test penicillin that way, it was the first chemical we had ever met which didn't do it. That was the chief thing that made us think that some day . . . but then we got down in a hole. This was way back in 1928 and 1929. We got stuck because this was a very unstable substance.

I have been talking about the culture. You could dilute the culture a thousand times, and it still would kill microbes or inhibit microbes. Before we go on, we might talk about that. Originally I did say "killed" microbes, actually kill bacterial cells, and I published a table to

show the rate of killing. Ten years afterwards when it was revived it was tested by a much more complicated procedure, and it was said that it only stopped the growth and did not kill. However, it has been amply shown now that it does kill, and the statement that has appeared in a great many papers that penicillin only stops the growth of microbes is wrong. It kills them as well.

Now to go back, I was talking about the instability of this substance. You have a chemical that you can dilute a thousand times, and it still stops the growth of microbes. That is today. A week hence it has no power at all, maybe. If you keep it in an ice chest, it keeps for a little while longer. Still, we never could keep it active for more than a few weeks. Then we tried to concentrate it, and we failed miserably. So, we were left there. We thought we had some good stuff, but we couldn't get along with it because we couldn't concentrate it. Our efforts at our laboratory were just unsuccessful.

Then at another school in London a very good chemist set to work on this. He improved the culture medium. He used certain methods to extract this stuff, and he succeeded only up to a point. He was getting on, but he was a chemist. The only test of the potency of penicillin was bacteriologic, so he had to have bacteriologists coöperating with him. The bacteriologists in his institution didn't seem to think much of his research, so they didn't coöperate, and he was stuck. He was stuck for want of bacteriologists, and we were stuck for want of chemists. He published his results, and when we saw that this good chemist had failed to extract it, we stopped doing anything about it. If he couldn't, we couldn't. It just got left about for 8 or 10 years.

Then it was taken up again at Oxford by Florey and Chain and their colleagues. They used this same culture medium, and they used an extraction method which was very nearly the same as that used by Raistrick but not quite, and they succeeded. A little difference in the

method made all the difference. They succeeded, and they got out of this culture a substance which you could dilute not 1 in 1,000, but something approaching 1 in 1,000,000. They concentrated it that much, and they were able to dry it. When you dry the stuff and keep it dry, then it is stable, and you can collect enough to do things with. As long as you have water with it, it is unstable. That is so now. I mean it is the same with the penicillin nowadays that you can buy. It is stable as long as you keep it dry, but you cannot expect it to remain stable for a very long time when it is moist.

They tested it on a great variety of microbes and, as we had done also, they made a list of the insensitive ones and the sensitive ones. The two lists coincided perfectly, except that the Oxford one was rather more extensive. They tested on animals and it was nontoxic; they tested on leukocytes, and it was nontoxic. Then they injected it into animals that they had infected.

There is an important thing that comes in here, the difference in the whole aspect of the medical man between 1930 and 1940. In 1930 we were all very skeptical about any chemical killing any microbe inside the body, except possibly 606, and that happened way back in 1907 or 1908. Many chemicals had been propounded for the treatment of microbes within the body, and many had been recommended for injection into the blood stream to kill microbes in the blood stream; and when you came to test them by the method I have illustrated here, you found that they killed the blood corpuscles much more than they killed the bacteria. None of them was successful. That was the position in 1930.

About 1935, 1936 and 1937, the sulfonamide drugs came in. By 1938 everybody was wanting to treat every disease under the sun with a chemical. The first thing that happened to any man infected with a bacterial disease was to give him sulfonamide and you tried to cure

him after that. The change in attitude was enormous.

It was at that time that the Oxford people went to work. They used the orthodox methods of test. They used mice that they infected with staphylococci, streptococci, and vibrios septique. Some of those mice they treated with very minute quantities of penicillin, and some of them they didn't. The untreated ones died in 17 hours, and the others all lived.

Then they tried it on men, and at first they got just what you would expect. Anyone going into a ward and saying, "I have got something which I think is good. Have you got a patient you would like me to try it on?" often gets somebody who is about dead. Everything else has been tried on him, and he is expected to bring him back from the grave. Actually, even in that series of cases the results were sufficient to show that this concentrated penicillin was very remarkable stuff.

Then they made some more. They got a better lot of cases the second time, and from the results of the second series there was no doubt that this concentrated penicillin was an exceedingly powerful therapeutic agent.

The final difficulty was to make it in quantity. There was nobody making it then except this laboratory at Oxford. They couldn't make enough. It was very difficult at that time because we were being bombed, and also our factories were all out to make things to hit the Germans. Florey came over here and got people interested, and then began the American interest in penicillin, a very important interest, too.

I have not yet told you the name of the mold that makes penicillin. To begin with, I didn't know what it was. I knew it was a penicillium, but that was as near as I could get. Then we got a mycologist, and I handed the culture over to him and asked him what it was. He examined it and said it was *Penicillium rubrum*. It made a yellow color, so I couldn't see why it should be a rubrum. But he was the expert

and I wasn't, so I accepted that and it was published as *Penicillium rubrum*. Later it was sent to an eminent mycologist on the continent of Europe who gave it some other name. I forget what he called it; it was also wrong. Then it came here to Dr. Thom, and he called it *Penicillium notatum*. As far as I remember, he hedged by saying it wasn't quite like his own stock culture. That gave him a way out if it proved to be wrong. It wasn't wrong.

This culture was brought to the United States. The National Research Council became interested, and they got manufacturers interested. The Agriculture Department and Dr. Coghill and his staff in Peoria became interested. Then things began to happen. They found that if they added something called corn-steep liquor to the culture medium, they got an enormously greater yield of penicillin. Peoria is in the heart of the corn country and they are always trying to find new uses for the corn-steep liquor. That was a great advance in the actual production.

In the early days of making it, it was all made by growing on the surface of fluid in bottles just the same as we had done originally. To make any quantity of it you had to have multitudes of bottles, 20,000, 30,000, or 40,000 bottles a day being handled, the fluid from those being poured off and treated. That was a laborious procedure.

Then some other person (I don't quite know who this was, but in any case it was on this side) said to himself, "Why grow it in bottles? Why not grow it in tanks?" It will grow just as well if you grow it in deep culture, in a lot of fluid, so long as you give it a lot of air. That is why you grow it on the top, to give it air. They had the deep tanks, they furnished it with air and the culture medium, and kept it at the proper temperature. They found that they could get a better yield, not so much better, but you can say that it is a better yield even if it is only the same potency per c.c. of fluid,

since it is so much easier to do it in big tanks than it is in bottles.

Now they are growing it in 10,000- up to 15,000-gallon tanks. It is no longer a laboratory method of production. I have been going down to some of the places where they make it on a large scale. I went into one of them and found a beautiful, clean place. I saw great engines and all sorts of things. It looked like an elaborate plant. Then they explained that this was simply supplying the air to the tanks up above. Then we went up above to the tanks. Of course, they were enormous tanks, 15,000-gallon tanks. There seemed to be tubes going in every sort of place and steam playing on all the ends of the tubes, a most elaborate contraption. They are producing penicillin in that way in large quantities.

After they have produced it in the tanks, then they have to get the penicillin out from the fluid. They do that by various methods. We needn't go into that. It goes through a series of tubes and comes out as concentrated penicillin. It is dried in ampules, and that is sent out for use by doctors. That is the stuff you get. It is not pure penicillin but penicillin that has been purified up to a point. The original Oxford concentrated penicillin was something less than 1 per cent pure. Now they are getting up to something like 50 per cent pure and it is getting stronger and stronger as better and better methods of extraction are devised.

We have this now, and it is up to us to use it. In the beginning it was used as an injection, generally intramuscularly, but it doesn't matter much whether you give it intramuscularly or intravenously or subcutaneously. It quickly gets into the blood and from the blood gets all through the body and into the infected area.

But there is a very serious drawback to penicillin, and that is that it is excreted very quickly. So, the injections have to be repeated every 2 or 3 hours to keep up a concentration in the blood which affects microbes.

There are very few things that you have to

think about, really, very few principles in penicillin treatment. One is that you have got to use it on the right microbe. It affects some, not others. If you use it on a man who is infected with the wrong microbe, an insensitive microbe, it is not going to do any good. You are just wasting your time and the penicillin. Bring a bacteriologist in and see if it is the right infection. I don't know how it is here in this country, whether you use bacteriologists in general practice, but they are not used half enough in England, and it is very good to see something coming in which makes it desirable that the practitioner should know something about what he is doing instead of just treating patients blindly. That is the first thing, to know what microbe you are treating.

The next thing is to get penicillin to the microbe. There are two ways of doing that. One is to inject it or get it into the body in some way by which it gets into the blood and gets at the microbe through the circulation. The other way is to put it on the infected spot so that the penicillin gets at the microbes locally. You can do that only if the infection is relatively superficial. You can do it sometimes by injecting it. You have to think of how you can get it there. Penicillin won't jump or fly. It is just a chemical, and if you want it to work you have to put it in contact with the microbes in some way. I think we have used local treatment more than you have, and for a very simple reason. You have had more penicillin than we have. It is very economical of penicillin to use the local treatment, but it is much more difficult, more time-consuming, and sometimes is not so effective.

You have those two things. Use it on a sensitive microbe, and then get it at the microbe.

The third thing is to keep the concentration up in the body. I told you that if you use simple injection, you have to inject every 2 or 3 hours. Everybody, I think, who has played with penicillin for a while is convinced

that injections every 2 or 3 hours over a period of days or maybe weeks is not a thing that is going to be very popular with the patient or the doctor. That is too many injections. So, everybody has been trying to diminish the number of injections or to do away with them altogether. Here at Walter Reed Hospital we have seen one method of giving fewer injections, 1 or 2 a day, by incorporating the penicillin in peanut oil and beeswax. It seems to be very successful. If you are going to give only 1 injection a day to the patient, the patient doesn't seriously mind it, and it is within the power of the doctor to call on his patient once a day or even twice and give injections; but it is not possible for him to go every 2 or 3 hours.

At the same time, it may be that the peanut oil and beeswax may not be necessary. Just before I came from England I saw a naval surgeon who was treating syphilis by giving 1 injection a day of a watery solution. He treated a hundred patients, and the results clinically and on serum tests were exactly the same as injections every 3 hours over the same period. So it is possible that we can cut down the injections a little by giving bigger doses.

The other thing is to give it by mouth. That is what we all want to do. To begin with, it was shown that penicillin given by mouth got in contact with the acid gastric juice, and the gastric juice was so acid that it decomposed the penicillin very quickly. But all the penicillin was not decomposed, and it isn't everybody who has a pH of 2 in his stomach. It is possible to get penicillin absorbed in the stomach, but the amount that gets in, as reported by the different observers, seems to be between one third and one fifth of the amount given.

So, if you are giving it by mouth, you have got to give 3 to 5 times the dose that you would give through injection. That is all right when you have lots of penicillin. When you are vitally short of penicillin, it seems hardly the thing to do.

I am told also that penicillin is going to be

released for oral administration in the United States very shortly, and I have no doubt that patients will demand it by mouth and get it by mouth, but there is one thing to remember. If you are giving penicillin by mouth, give enough. Don't skimp the dose, because when you skimp the dose there is a tendency for the microbe to take advantage of it, and it educates itself against the drug. Certainly it did with the sulfonamides. It is not so easy for it to educate itself to penicillin, but it can be done. Then you see what happens. We won't bring the doctor into this at all. The patient goes and buys some penicillin and takes it by mouth, and he takes too small doses. He doesn't get rid of the microbes, but he educates them and they become penicillin-fast. Then he passes them on to somebody else, who becomes a temporary carrier. He doesn't get anything, and he passes them on to somebody else. That man may pass them on to somebody else, and then some day someone gets this resistant microbe and has pneumonia. Then you try to cure it with penicillin, and you can't. That means that the first man, who doctored himself ineffectively with penicillin, who gave himself too small doses, is really responsible for the death of the last man, because he produced penicillin-resistant organisms.

Penicillin appears to be available in quantity. There is no need to give too small doses. Give big enough doses and try to prevent the establishment of acid-fast microbes, as happened with the sulfonamides. You cannot give a poisonous dose.

I am not giving the details of the treatment, but generally if you use it on a sensitive microbe, not an insensitive one, and then take precautions that the penicillin gets at the microbe with doses given sufficiently often and of sufficient size that the penicillin remains in the body for a reasonable time, the results will be good; but if you play with penicillin, treat the wrong microbe, or give it in ineffective doses, you are going to be disappointed.

A NOTE ON INFECTION AND CANCER

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AS EARLY as 1867 Busch noted that a case of sarcoma recovered after an attack of erysipelas, and occasional reports of recovery from malignancy following infections have been appearing ever since. Loeb¹ in 1910 reported that a severe attack of influenza seemed to have cured cancer in a patient and noted that "certain other acute infectious diseases may likewise cause retrogression of cancer," while B. A. Thomas reported the cure of a malignant tumor of the mouth after an attack of grippe in the discussion that followed. I myself remember reading of a recovery from cancer following a severe staphylococcal infection. Coley's vaccine, a mixture of streptococci and *B. prodigiosus*, has also been used in the treatment of sarcoma with some success.

Apparently there is no doubt that various infections influence the course of malignant disease, and that they may lessen its incidence is indicated by the fact that cancer was less frequent when infections were more frequent, before the days of preventive medicine. Sickly children, who have come down with one infection after another, are also likely to be stunted, indicating an influence on normal growth. The exact nature of the relationship is unknown, but agents as widely different as streptococci and the influenza virus are involved, and ability to produce nonspecific antibodies and reactions is about the only property they have in common in animals. However, this point does not seem to have been stressed, in spite of the fact that some of these antibodies inhibit the multiplication of nonspecific organisms and thus might have a similar action against other cells, including malignant ones, while some of the reactions have to do with metabolism.

According to Little's theory,² orderly growth is really an abnormality, due to the presence of some restraining factor, since unicellular organisms multiply indefinitely in nature. Cancer inhibits or destroys this abnormal, restraining factor and in this way causes the cells to revert to the normal method of unrestrained growth. But bacteria do not grow indefinitely in colonies. The products of growth quickly inhibit further multiplication, and similarly multicellular tissues might be limited in growth by their own products. Ulceration would tend to drain off these products, and the ulcer might become malignant when their loss upsets the balance between stimulation and inhibition. Possibly an increased cellular metabolism, during and following recovery from a severe infection, or nonspecific antibody production results in the formation of a reserve of inhibiting substances which restores the balance. It is even possible that the reverse condition has a connection with the origin of cancer, since the decreased metabolism of old age gives off a comparatively small amount of the products of growth, and that an increase in metabolism would be beneficial.

Many metabolic factors are involved in the complex make-up of higher animals that do not apply to simpler forms of life, but those controlling simple forms are basic and, therefore, should be included in more highly specialized systems. Bacterial growth is largely controlled by a balance between two factors. One stimulates and must be inherent in the individual cell, because a single organism divides without aid from other cells. The other inhibits and is a product of the growth that is due to the activity of the stimulating factor. Its strength increases with its concentration. Scattered cells, in the presence of a minimum of the products of

growth, are dominated by the stimulating factor and grow without restraint, but whenever conditions are such as to bring about a circumscribed collection of cells growth becomes controlled by the collective action of the group. Animal organs are collections of cells.

In chronic ulcers the cells are not completely circumscribed, and loss of inhibitory products through drainage strengthens the stimulating factor in the epithelium around the lesion, enabling it to attempt repair. Growth is still limited, however, because an increased amount of the products from stimulated growth makes good the loss. However, the stimulating factor cannot be expected to remain strong indefinitely in the presence of a pathologic condition which continually incites it to further effort by draining off the inhibiting factor. In the course of time, strained by constant activity from loss of inhibition, it weakens, as everything does under long-continued, excessive strain, until it reaches the point where it can no longer respond to decreased inhibition by an adequate increase in strength. The cells are partially paralyzed and their products, therefore, are not only minimal, but atypical, and contain little normal inhibitory principle, too little to restrain growth at the site of the ulcer where the inhibitory element is being drained away. Disease of the cells may also result in such a rapid exudation of the products that they have not time to function.

An automatic brake is thus removed and, in the presence of a strong carcinogen, this series of events may be sufficient to bring about the change from normal to cancerous cell. The carcinogen neutralizes the inhibiting factor, as in Little's theory, but the transformation is not due to reversion, but to a consequent radical alteration in the properties of the epithelium which prevents it from limiting its growth by its own products.

However, the process is often less acute, and growth may be restrained for some time by the collective action of normal cells in the vicinity.

A reserve of inhibitory products continues to function, but, as metabolism diminishes with age, this reserve decreases; and, in addition, loss of inhibition is proportionally greater than loss of stimulation, because inhibitory products come from numerous cells, while the stimulating factor is a property of the individual cell. This is a relation which, by itself, tends to make inhibition lose control of stimulation. Great depletion of the reserve ensues from failure of mass production of the inhibitory element, until it ceases to be a substitute for the altered products of the diseased cells whose automatic machinery to limit growth has already been broken. Uncontrolled multiplication follows, and a new variety of tissue is born in which an actually weak but relatively strong stimulating factor operates without restraint, although worn out by strain and age. Cancer is not a matter of reversion but of obedience to the law that all things weaken and suffer loss of function under excessive strain.

By restoring the reserve of inhibitory products it may be possible to renew control of growth, but, in any case, some curative principle evidently is present in infections, and this principle appears along with immunity to the specific organism, so that, quite possibly, the degree of immunity and the number of nonspecific antibodies formed measure its effectiveness. Such a control would help standardize treatment of cancer by means of infectious organisms, while lack of any standard, together with inability to produce major reactions without killing the patient, may have had a great deal to do with many of the failures in treatment.

Busch inoculated a patient with sarcoma with erysipelas as a result of his observation that recovery followed a natural attack of the disease, but succeeded only in causing temporary improvement. Others did report some permanent cures by this method, according to Leo Loeb,¹ and living streptococci were used later with favorable results when the patients survived the treatment; but viable organisms were too

dangerous and Coley's vaccine was substituted, again with a few reported cures and many failures. Improvement almost always occurred, but was rarely permanent. On the other hand, the severity of the natural infections resulting in recovery was sometimes noted. The patient's life is despaired of, but he gets well and the malignancy vanishes. This favorable result, of course, is associated with many unknown elements, but the extent of the body's reaction to a major infection must be an important factor. Something that cures is produced by the body in response to infection, and the greater the virulence of the infecting organisms, the greater this response must be, if the patient is to survive. To make full use of the curative principle that is present in organisms, virulent, living bacteria should be employed instead of vaccines.

This procedure was abandoned because it was uncontrollable. Too many died from the inoculations. Now, however, penicillin provides an easy method for controlling pyogenic and

other infections. *Staphylococcus aureus* can be applied to the skin with safety until a maximum immunity is reached and other organisms used later to obtain the greatest possible response of the body to infection. The increase in specific and nonspecific antibodies should be a measure for a standardized reaction.

The method simulates a natural process that seemingly has cured hopeless cases of cancer and is likely to reveal more than experiments on laboratory animals in this instance, since age and chronic lesions appear to be minor factors in the latter. All disease is also a matter of action and reaction, and the strength of the attack is overwhelming in induced cancer and in cancer with a very high incidence in inbred animals. In these types the increase in inhibitory products would have to be very large to have any effect.

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THE SYMPTOMATOLOGY OF INFECTIOUS MONONUCLEOSIS

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P HYSICIANS individually encounter relatively few cases of infectious mononucleosis and may therefore be slow in recognizing the disease. This delay is not serious since there is no specific treatment and the prognosis is favorable even when the patient appears very ill. However, worry and confusion are avoided when the diagnosis can be made early in the course of the disease. An immediate difficulty in this regard is the variability of the clinical manifestations. This variability was well demonstrated in a series of 13 cases observed at the Georgetown University Hospital. The essential data in these cases have been tabulated (table 1).

In this series there were 10 males and 3 females. All were white patients. Four were in the second decade and eight in the third decade of life, and one was 48 years old.

All patients complained of generalized aching and had been running fever for 3 days or longer prior to admission to the hospital. In 3 cases headache was unusually severe and unresponsive to ordinary analgesics. In 9 cases sore throat was the predominant complaint. Swollen glands had been noticed for 3 days or more prior to admission by 8 of the patients. One patient was admitted for study because of fever of unknown etiology.

The physical findings included enlargement of the cervical, axillary and inguinal lymph nodes in all cases. The epitrochlear and submandibular nodes were also enlarged in six of them. The nodes were easily palpable, discrete, and usually non-tender. Their size varied, but in general they were 1.5 to 2.5 cm. in diameter. The larger nodes were seen most

frequently in the cervical region. In one case, the nodes in the submandibular and anterior superior cervical regions were as large as lemons. The auricular nodes were enlarged in 2 cases.

The spleen was easily felt in 9 of the 13 cases. However, it never extended more than a few centimeters below the costal margin. Usually it was tender. In addition, the liver was slightly enlarged in 2 cases.

In 9 cases there was severe pharyngitis. The tonsils were acutely inflamed in 6 cases, the type of involvement varying from follicular to pseudomembranous tonsillitis. Vincent's organism was recovered from the tonsils in all cases.

The hospital stay was uneventful in 11 of the cases. Two patients developed jaundice while in the hospital. It disappeared after 2 days in one and after 7 days in the other. In 2 cases there was physical and roentgenologic evidence of bronchopneumonia. In 2 cases there was a diffuse, erythematous, macular rash involving the trunk and extremities. All of the patients recovered.

REVIEW OF RECENT LITERATURE

One of the confusing symptoms of infectious mononucleosis is abdominal pain with vomiting. This is attributed to involvement of the mesenteric lymph nodes, and is easily mistaken for acute appendicitis. Appendectomies were performed in 2 reported cases. The patients complained of severe abdominal pain, nausea and vomiting. They had fever and leukocytosis as well as marked tenderness with rigidity over McBurney's point.^{1,2} Grossly and microscopically the appendix was normal in each case. A lymph node taken from the region of the ap-

TABLE 1
Clinical Data in 13 Cases of Infectious Mononucleosis

CASE NO.	AGE	SEX	SYMPTOMS	PHYSICAL FINDINGS	LEUKOCYTE RESPONSE	HETERO-PHILE AGGLUTINATION TITER	TREATMENT	COURSE
1	14	F	Fever Sore throat Swollen glands Muscle pains	Generalized lymphadenopathy Spleen not palpable Tonsillitis, pharyngitis	Leukopenia Mononuclears: 62%	1:660	Symptomatic	Temperature normal in 7 days
2	12	M	Fever Headache Muscle pains	Generalized lymphadenopathy Splenomegaly	14,250 Mononuclears: 71%	1:896	Symptomatic	Temperature normal in 6 days
3	18	M	Fever Fatigue	Cervical lymphadenopathy Spleen not palpable	18,100 Mononuclears: 59%	1:228	Symptomatic	Temperature normal in 7 days
4	19	M	Fever Sore throat Muscle pains Headache Swollen glands	Generalized lymphadenopathy Spleen not palpable Tonsillitis	7,000 Mononuclears: 65%	1:1784	Penicillin Neoarsphenamine in glycerin locally	Temperature normal in 5 days
5	21	M	Fever Sore throat Fatigue Swollen glands	Cervical lymphadenopathy Splenomegaly Hepatomegaly Tonsillitis	9,000 Mononuclears: 54%	Not done	Symptomatic	Temperature normal in 5 days
6	24	M	Fever Sore throat Muscle pains Swollen glands	Cervical lymphadenopathy Splenomegaly Pharyngitis	18,000 Mononuclears: 71%	1:448	Symptomatic	Temperature normal in 4 days
7	24	M	Fever Sore throat Muscle pains Headache	Cervical lymphadenopathy Splenomegaly Pharyngitis	24,000 Mononuclears: 71%	1:3584	Symptomatic	Temperature normal in 7 days
8	29	M	Fever Sore throat Muscle pains	Cervical lymphadenopathy Splenomegaly Tonsillitis, pharyngitis	20,000 Mononuclears: 52%	Not done	Symptomatic	Temperature normal in 5 days
9	23	M	Fever Swollen glands Muscle pains	Cervical lymphadenopathy Splenomegaly Tonsillitis	4,200 Mononuclears: 61%	1:1084	Symptomatic	Temperature normal in 4 days
10	22	F	Fever Swollen glands Muscle pains	Cervical lymphadenopathy Splenomegaly Tonsillitis Jaundice	10,000 Mononuclears: 59%	1:3584	Sulfathiazole	Temperature normal in 10 days Jaundiced throughout

TABLE 1—Continued

CASE NO.	AGE	SEX	SYMPTOMS	PHYSICAL FINDINGS	LEUKOCYTE RESPONSE	HETERO-PHILE AGGLUTINATION TITER	TREATMENT	COURSE
11	26	M	Fever Sore throat Muscle pains	Cervical lymphadenopathy Splenomegaly Tonsillitis, pharyngitis	5,500 Mononuclears: 61%	1:1084	Symptomatic	
12	28	M	Fever Sore throat Swollen glands Muscle pains	Cervical lymphadenopathy Splenomegaly Hepatomegaly Tonsillitis	25,000 Mononuclears: 59%	1:448	Sulfadiazine	Developed jaundice, bronchopneumonia which cleared in 10 days Rash lasting 2 days
13	48	F	Fever Night sweats Sore throat Swollen glands Muscle pains	Cervical lymphadenopathy Spleen not palpable	7,900 Mononuclears: 59%	1:896	Symptomatic	Temperature normal in 10 days

pendix in one case showed changes almost identical with those in nodes removed from other sites in cases of infectious mononucleosis. These patients who had appendectomies showed high diagnostic titers with the Paul-Bunnell test. It may be that so-called "mesenteric adenitis" is a manifestation of infectious mononucleosis more often than is suspected.

Another manifestation which is not too common is the syndrome which occurs when the central nervous system is involved in infectious mononucleosis. The symptoms may appear as early as two weeks prior to the characteristic lymphadenopathy and splenomegaly. The clinical picture has been erroneously diagnosed as acute lymphocytic choriomeningitis, acute toxic encephalitis, epidemic encephalitis and sometimes even poliomyelitis.^{1,3} Severe headache is the foremost complaint. Dulling of the sensorium from mild lethargy to coma occurs. There may be irritability progressing to delirium. Other symptoms are photophobia, nystagmus, poor articulation, and acute ataxia. Occasionally the second, third and seventh cranial nerves are involved, with corresponding weak-

ness or paralysis of the affected muscles. There are signs of meningeal irritation, with nuchal rigidity, Kernig's and Brudzinski's signs, and nausea and vomiting. Nuchal spasticity may also be due to enlargement of the cervical nodes. The spinal fluid usually has an increased cell count, from 25 to 1,000 cells/mm³. The great majority are lymphocytes. The proteins are usually increased; the Wassermann reaction and the colloidal gold curve are usually negative. The course of the disease is always favorable and there are no residual effects in the nervous system. The spinal fluid findings return to normal soon after the lymphadenopathy and fever subside. All cases reported had diagnostic titers of heterophile agglutination as well as typical blood smears.

Another important manifestation of infectious mononucleosis is jaundice. It usually follows the lymphadenopathy by 7 to 10 days, but this is not constant. The icterus index may go as high as 150. The serum bilirubin may rise as high as 22.5 mg./100 c.c., and the van den Bergh reaction is direct. Bile is present in the urine as is urobilin in increased amounts. One

case was reported to have had a biphasic van den Bergh reaction.^{1, 4}

The cause of the jaundice has not been proven. It is an obstructive type, but whether it is due to a form of hepatitis or to pressure upon the biliary tract by enlarged nodes or to a combination of these two mechanisms has not been settled. In the cases which formed the basis for this article the urinary urobilinogen was increased and bile was present in the stools when the usual obstructive findings in the blood were present. One case showed a low blood cholesterol value (60 mg. per 100 c.c.) which rose to normal after disappearance of the jaundice. Reports on cephalin flocculation and other liver function tests are lacking. If the jaundice is due to hepatitis, as the above data suggest, the cephalin flocculation reaction should be 3+ or 4+.

In one case,⁵ in which death was due to rupture of the spleen, autopsy disclosed diffuse focal hepatitis. The patient did not appear jaundiced at any time during the illness, although the liver was slightly enlarged and tender. The hepatitis consisted of scattered small- to large-sized foci of swollen reticulo-endothelial cells and numerous cells of the mononuclear type. These infiltrations were seen most frequently in the perilobular areas and some were located in the portal areas. Under the low power lens the infiltrations resembled those seen in leukemic involvement of the liver. The liver cells in these areas had been destroyed and had disappeared. The cells surrounding these areas contained mitotic figures and were generally swollen and enlarged.

Another manifestation occurring not uncommonly is a rash. It is usually maculopapular and appears and disappears in the manner of the contagious exanthemata. The trunk is predominantly involved, with some spread to the extremities. It rarely involves the palms and soles, and may resemble German measles or be

scarlatiniform. It appears after the first week and seldom lasts more than 4 days.^{4, 6}

A hemorrhagic tendency, usually in the form of epistaxis, is not uncommon, and the quantity of blood lost may be considerable. The pathogenesis for this development has not been definitely established, but it is believed to be due to thrombocytopenia. However, most patients having epistaxis do not develop purpuric rashes. Cases have been reported in which hematuria, bleeding gums, and epistaxis occurred. The platelet count was found to be "greatly reduced" although the counts were not recorded. The patients recovered. Patients developing purpura would naturally have a somewhat poorer prognosis.

SUMMARY

This discussion demonstrates that infectious mononucleosis varies considerably in its manifestations and severity. Children are affected as often as adults, and the disease may occur in epidemic form. Negroes are only rarely affected. The diagnostic criteria are the typical blood count and the Paul-Bunnell test. Although the clinical course may appear stormy, the disease is rarely fatal. Almost all patients recover completely.

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OUT-PATIENT PENICILLIN THERAPY OF GONORRHEA

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WITH the increased availability of penicillin a wider use of this drug for the treatment of gonorrhea in outpatient clinics is now practical. It is necessary, however, that as short a treatment schedule as possible be used compatible with a high rate of cure.

In a preliminary report¹ on the treatment of gonorrhea with penicillin on an outpatient basis a method was described in which a cure rate of 95.5 per cent was obtained among 98 patients. The method of treatment consisted of 4 intramuscular injections of 50,000 Oxford units (2 c.c. of solution) given at hourly intervals or a total of 200,000 units over a period of 3 hours. Patients were examined 24, 48 and 72 hours and 10 days after treatment.

Since this preliminary investigation we have treated 766 gonorrhea patients with 200,000 units of penicillin given in 4 equal hourly doses. It was believed, however, that 4 post-treatment examinations were unnecessary, since almost all patients having negative cultures 48 hours and 10 days after treatment could be considered cured. The criteria, therefore, for the successful treatment of these patients were 2 negative cultures within 10 days of treatment and the absence of, or marked improvement in clinical findings.

The patients treated were men and women who presented themselves at venereal disease clinics of the District of Columbia Health Department with clinical evidence of gonorrhea or were contacts to known cases of gonorrhea. The diagnosis in each case was confirmed bacteriologically by culture methods. The patients

were told to abstain from alcoholic beverages and coitus during the observation period following treatment.

A total of 776 (473 male and 303 female) patients have so far been treated by this method. Among the 473 males 137 (29 per cent) failed to report for follow-up observation, and of the 303 female patients 50 (16.5 per cent) failed to report. A total of 336 male patients were observed for 10 days, and 2 cultures were obtained. Of these, 39 or 11.6 per cent failed to respond to treatment. This is a cure rate of 88.4 per cent among the male patients. Twenty (7.9 per cent) of the 253 female patients from whom cultures were obtained were considered failures. This is a cure rate of 92.1 per cent among the female patients. In all cases the drug was well tolerated.

The higher cure rate among the women does not indicate a higher therapeutic efficiency of this method in women. It can be accounted for on the basis that the response in the male following treatment produces a more marked beneficial effect, and therefore a higher percentage of men fail to return. The patients who fail to return are, in most cases, probably cured, but they cannot be considered among the successfully treated cases. On the other hand, men who fail to respond to treatment and in whom symptoms remain do return for further examinations. The response to follow-up among the women was considerably higher than among the men, and therefore a more accurate measure of the cure rate was obtained.

If the total of 589 cases is considered in which

the criteria of cure were applied, 52 cases or 8.8 per cent failed to respond to treatment. This is a cure rate of 91.2 per cent among all patients.

A number of the failures were re-treated with a second and similar course as the first. Nineteen were so re-treated, with 2 failures (10.5 per cent) or a cure rate of 89.5 per cent. If the 17 cases are added to the successfully treated cases in the group having 1 course of treatment, an over-all cure rate of 94.1 per cent is obtained.

In most of the men treated cultures were usually negative in 24 to 48 hours, and clinical symptoms subsided rapidly, as early as 24 hours after treatment. The most acute cases, or those in which treatment was started within 2 or 3 days following the onset of symptoms, appeared to respond more rapidly and effectively than the more chronic cases. Although in some cases the urine remained cloudy or a slight discharge persisted for 7 to 10 days, the cultures and smears were usually negative. In the clinical failures the symptoms generally persisted and the discharge remained profuse.

In female patients cultures were necessarily considered of the utmost importance. Smears, frequently negative in infected women, cannot be relied upon to determine successful response to treatment. Cultures are reliable in most cases if they are transported to the laboratory within 4 to 6 hours. The absence of clinical findings in the female is not a criterion of the absence of infection, since gonorrhea in women is frequently in a quiescent state.

The possibility of reinfection shortly after treatment was considered, and in all cases of apparent failure of treatment careful histories as to exposure and contact information were obtained whenever possible.

It is important to bear in mind that penicillin therapy may delay the appearance of syphilis or lengthen the incubation period of this disease if it is contracted at the same time as the gonorrheal infection. Patients were, therefore, advised to return for further blood tests after 30, 60 and 90 days or sooner if symptoms of syphilis appeared.

Penicillin blood levels were taken on 4 patients. During the course of treatment, levels taken every 30 minutes showed concentrations as high as 0.25 to 0.50 units per c.c. of serum. Up to 3 hours after treatment the levels remained fairly high at 0.19 to 0.25 units.

These concentrations over a period of 7 hours are considered sufficient for the cure of gonorrhea.²

Our clinic procedure for the treatment of gonorrhea cases is now so organized that patients seen on one day are referred for treatment with penicillin on the following morning. The treatments are started at 9 a.m. and completed by 12 noon. We have found this schedule satisfactory for most patients, since a minimum of time is required to complete the treatments and only 2 further visits are required. On the second visit after treatment the result of the initial blood test is available.

SUMMARY

A total of 776 cases of gonorrhea were treated with 200,000 Oxford units of penicillin. A schedule was used consisting of 4 injections at hourly intervals of 50,000 units each. No reactions to the drug were noted. Two cultures 48 hours and 10 days after treatment were obtained in 589 cases. Patients failing to return for observation were not considered in the evaluation of the method. A cure rate of 91.2 per cent was obtained in patients receiving 1 course of treatment. Among the 52 patients who were considered treatment failures 19 were re-treated with a second course of 200,000 units. Seventeen of these responded successfully. This would give an over-all cure rate of 94.1 per cent.

Blood levels of from 0.19 to 0.25 units per c.c. of serum were maintained for at least 3 hours after treatment in 4 cases.

This method of treatment may be considered highly satisfactory as an outpatient procedure in the treatment of gonorrhea.

(Continued on page 439)

President's Page

WHAT I LEARNED FROM MAINE VILLAGERS

I am writing this from Southwest Harbor, Maine. Last night after dinner we tuned in on the radio just as the surrender of Japan was being announced. First a ship in the harbor started blowing excited blasts with its whistle. Then the siren at the village fire house joined in with automobile horns. Still later the church bells were rung and for a little town we put on a real celebration of gladness that the war was over. It is good to have a vacation and be at a village like this at such a time. They are good folks here, these Islanders. I noticed on their roll of honor so many good local names like Gilly, Stanley, Sargent, Fernald, Bunker and Rich. These families have lived on the Island for generations. Some of them own stores in the village. Others are lobstermen, fishermen or men working in the shipyard. Still others are carpenters or iron workers or run small dairy farms. Having spent many summers here we get to know them well and they are a keen, hard working, effective people. They are good citizens and not only are interested in the local government but they have excellent ideas on the national government. This town is free of debt and has thousands of dollars in reserve. The thing that impresses me is their interest and how they participate in their local government. Someone has wisely said that it is not in Wall Street but in small towns like this where it is decided who the next president will be. I have just been talking to the owner of the shipyard and he had most excellent ideas on reconversion. There is something about simplicity and soundness of thinking that make issues seem clearer.

I thought of the Medical Society in connection with all this. It seemed to me there was a relationship between the running of a village and the organization and activity of the Medical Society. I wondered if we had the same proportion of members that were as vitally interested and active in conducting the affairs of the Society as were active in conducting the running of this town. From the response of men that were asked to serve on committees I would feel that the interest was much the same. I believe tremendously in what happens when a group of men are giving thought to a problem, especially if they have the opportunity to express their opinions—in friendly discussion.

With the war at an end the problems of reconversion will need our best thought and judgment. Maybe the shift of government in England does not have much bearing on the way things are shaping in our country but I for one think there are similar trends here. We must be increasingly interested and aware of how the practice of medicine will have to fit into these newer social trends. I am an optimist and feel these problems are a challenge and I am sure we will work out plans that will keep our profession at the same high level it has maintained in the past.

Wm. Earl Clark

Editorials

THE TREND IS TO THE LEFT

The Labor Party's victory in the recent British election was not entirely unexpected. In fact, trained observers had been suggesting the possibility for some time. But not one of them would have been so bold as to prophesy an overwhelming Laborite majority. This was a surprise. What did it mean? Were European nations—even staid England—prepared to embrace Communism?

It would be unwise to draw hasty conclusions. However, information at hand would seem to indicate that socialism will hold sway in England but not to the extent that some thought probable. Communism, it appears, is not remotely possible for there is little love lost between Socialists and Communists. But let there be no mistake about the course Britain has taken. She has gone further to the left than most informed Americans thought possible.

The British medical profession already knows where it stands. Shortly after his election, Prime Minister Atlee expressed himself as follows:

"The policy of the Labor Government may be summed up as a fair return to the producer; an ample supply of good and wholesome food at reasonable prices to the consumer; full use of the resources of science; well planned distribution, transport and marketing and a bountiful and prosperous countryside."

"Labor ministers took a big part in working out the comprehensive schemes for social insurance proposed by the late government in power. It will seek to implement and improve upon them."

It is no secret that the Labor Government is for the complete socialization of medicine in England. Edward Murrow, CBS's London observer, reported a few weeks ago that the British Medical Association, which he described

as "the great medical labor union," would soon be locked in a desperate struggle with the government. He predicted that the issues involved would be settled by compromise.

Among the writers in this country who have commented upon the British election is Joseph H. Baird. Writing in *The Sunday Star* (Washington) of July 9, he has this to say:

"... the tremendous Labor victory is explained by Washington officials who are well acquainted with present political trends in Britain on two grounds: First, the vote reflected war-weariness, a desire to forget an administration which was closely identified with the days of the great 'blitz' and rocket bombs and threats of invasion—an emotional groundswell similar to that which caused Americans in 1920 to follow Warren G. Harding 'back to normalcy.'"

"Second—and in a more concrete realm—the average British voter apparently was convinced that the Labor party, with its socialistic program of nationalizing basic industries and following very paternalistic economic policies toward the individual, offered him more than the Conservatives. A Labor victory, to this typical voter, represented better housing, surer employment, higher pay, more pension—if he were a serviceman—and a broader system of social insurance.

"The latter point is interesting, inasmuch as the Churchill coalition government had drawn up and attempted to sell the public an extremely broad-gauged series of postwar plans which, even a few years ago, would have been regarded as extremely socialistic. Beginning with Sir William Beveridge's advanced plan for social insurance, first announced in November, 1942, and later incorporated in a government White Paper, the Churchill government had followed through with blueprints for a national health service to include widows' pensions, retirement pensions, family allowances, maternity grants and death grants; an education plan, actually embodied in legislation in July, 1943, for a wide extension of publicly-supported schools, a postwar housing plan and an elaborate scheme to curb unemployment.

"But the 'little man' in Britain apparently distrusted either the good faith or the ability of the Conservative

Victory!

V-E Day

MAY 8, 1945

V-J Day

SEPTEMBER 2, 1945

we honor those who served

280 MEMBERS OF THE MEDICAL SOCIETY

OF THE DISTRICT OF COLUMBIA

HAVE SERVED WITH THE ARMED FORCES

party, which he regards as the traditional defender of big business and the landed gentry, to carry through such a socialistic program."

Senator Burton K. Wheeler of Montana believes that this country will turn to the right rather than to the left. He says that our country has become restive under reform regimentation and that, particularly in war years, an anxiety to dismantle control has arisen. "From what I have come to know personally," the Senator asserts, "the conservative elements should win in the next Congressional elections and may win the Presidential election in 1948. You can't have the Government stop spending \$100,000,000,000 a year and cut it down to \$25,000,000,000 or so, as we must do, without having economic dislocation. Anybody who thinks you can is crazy. This Nation is in for one of the most serious economic periods in its history."

However, this view is discounted by the Senator's critics. They say that this is wishful thinking, pointing out that as a prophet the Senator erred in the British election which, he said on his return from abroad, would retain

Winston Churchill. Anyway, the logic of the Senator's arguments is questionable. If the country's income drops as much as he says it will, that will be just the time when the public will demand more from the Government.

What does this all add up to? The fact is that the trend not only in this country but in Europe has been left since the early 1930's—yes, before that. Considerable social legislation has been enacted in the United States which at the time of its passage was thought radical. Today it is accepted as desirable even by conservatives. There is no reason to believe that history will not repeat itself considering the vast social problems which will demand solution following this greatest of all wars.

If these conclusions are accepted, one may expect that many legislative panaceas will be offered. Physicians cannot ignore them, they must deal honestly and objectively with them. And what is very important, there must be no room for doubt that physicians really believe that what is good for the people is good for the medical profession.

T. W.

VARIATIONS IN NORMAL LEUKOCYTES

Since certain valuable drugs may exhibit their toxicity by the reduction of the leukocyte count, it is well to review the variations one may expect in normal white blood cells. Under normal conditions there are spontaneous and irregular fluctuations in the total number of leukocytes and in the percentages of the different varieties of white corpuscles. Recognition of the cause and extent of such physiologic variations in leukocyte counts is important when they are made the basis for continuing or abandoning a form of treatment. Take, for example, sulfonamide therapy, during the course of which a decrease in the white blood cells has been regarded as evidence of toxicity, and as

an indication for abandonment of the treatment, even though the decrease has been within normal variations. Such a misinterpretation may lead to withholding an exceedingly valuable or perhaps lifesaving drug.

The following mechanisms, alone or in combination, are probably responsible for variations in the white cell count: 1. Alterations in the rate of production of leukocytes. A decreased white blood count may result from simple inhibition or maturation-arrest in the bone marrow, while an increase is dependent on simple hyperplasia or accelerated maturation. 2. Variations which depend on changes in rate of destruction or elimination of leukocytes from

the body. 3. Variations due to difference in the concentration of the circulating blood plasma. 4. Redistribution of the white blood cells in the vascular channels. Recent evidence confirms the earlier belief that this mechanism is the basis for most of the physiologic variations in the leukocyte count.

Daily and hourly fluctuations in leukocyte counts have long been known and were attributed to mild exercise and digestive activity but recently have been shown to be independent of these factors. The fluctuations are irregular and sometimes pronounced. Counts done in the morning under conditions of rest (5,000 to 7,000) show the least variation, and after an hour of rest in the afternoon 90 per cent of them fall within morning limits. Unpredictable and irregular variations in the leukocyte and differential counts do occur in normal individuals, but to be significant they should exceed 50 per cent of the total count and 8 per cent of the differential.

Leukocytes increase in the circulating blood following muscular exertion roughly in proportion to the duration and severity of the muscular contractions. Leukocyte counts are lowest during periods of minimal activity. Marathon runners exhibit a leukocytosis of 14,000 to 27,000, with the polymorphonuclear leukocytes ranging from 80 per cent to 90 per cent. A leukocytosis of 35,000 has been noted after a quarter-mile race. Football players show a 300 per cent increase in their white blood count, even though the actual playing time in a 60-minute game is but 8 minutes. The rapidity of increase in cell count indicates that it results from redistribution of leukocytes in the vascular system rather than from the formation of new ones. The cells appear mature, adult in type, with clear-cut lobulation. The leukocytosis of exercise is proportional to the acceleration of the circulatory rate, i.e., the greater the acceleration, the more cells are swept into the blood stream. The chief factor in this prompt leukocytic response is dilatation of the collapsed

capillaries in the muscles. During inactivity vast numbers of leukocytes are adherent to collapsed vessel walls, but they are detached and swept into the circulation when the capillaries open during exercise. The spleen may be a reservoir and its contraction a factor in leukocytosis; however, it has been shown that after splenectomy an injection of adrenalin produces as much physiologic leukocytosis as before the spleen was removed. In short, any condition which augments the circulatory rate, whether it be competitive sport, the labor of pregnancy, or an epileptic seizure, will produce a leukocytosis.

Leukocytosis may also be due to a relative and absolute increase in the lymphocytes, especially after a short burst of intensive exercise, since exertion has long been known to increase the flow of lymph, which washes lymphocytes out of the lymphatic reservoirs into the general circulation. The leukocytic response to exercise may come either from the polymorphonuclear leukocytes which have been idling in collapsed capillaries or from collections of lymphocytes in the lymphatic system. Thus, brief, strenuous exercise is prone to elicit a lymphocytic response, while more prolonged exercise induces a polymorphonuclear leukocytosis.

Vejlens¹ (1938) observations have been of great value in clarifying the mechanism of leukocytosis in physiologic and pathologic conditions. He noted that under normal conditions some leukocytes flow axially in the veins, while others adhere to the vessel walls. These marginal cells are always neutrophils. He stated that any increase or decrease in marginal leukocytes in venules accounted for changes in leukocytic distribution. The factors governing the position of leukocytes in the blood stream are, first, alterations in the rate of circulation, and second, variations in the suspension stability of blood plasma, which is probably related to

¹ Vejens, G.: *Acta path. et microbiol. Scandinav.*, 1938, supp. 33, p. 1.

its fibrinogen content. According to this theory, a decreased rate of blood flow produces a reduction in the white blood count by permitting more corpuscles to remain in marginal positions and become loosely adherent to the vessel walls, while a more abundant flow of blood throws the lagging white blood cells into the circulation to increase the leukocyte count in the peripheral blood stream. In certain pathologic conditions, such as infections, fibrinogen is increased, a fact which may also account for the marginal position of the neutrophils.

Shortly after birth the average leukocyte count is 25,000. It falls to 14,000 on the tenth day of life and gradually declines during infancy and childhood. The average white blood count of children from 4 to 7 years old is 10,400; at 8 years the average declines to 8,400. At birth neutrophils predominate, but their relative and absolute numbers diminish during the second week of life and are exceeded by the number of lymphocytes. The lymphocytes gradually decrease after the first year but remain the most numerous until the fourth year, when they are surpassed by the neutrophils. Basophils and eosinophils remain uniform throughout infancy and childhood at about adult numbers. In children mild infectious processes produce either leukocytosis or leukopenia, depending upon the responsible agent, and such changes tend to persist for some time after the subsidence of the disease. After 18 years of age the adult leukocyte count of 7,400 is observed.

The leukocyte count rises during pregnancy, the increase being due to a greater number of neutrophils, with a higher percentage of younger forms than in nonpregnant women. The average count is 10,000 to 11,000 regardless of the month of gestation, or whether the patient is a primipara or multipara. The neutrophils increase through the seventh month of pregnancy. The total count declines from the fifth to ninth week post partum, chiefly at the expense of the neutrophils. At the onset of labor the leukocyte

count rises about 2,000, increasing to the maximum at delivery, the average being 22,500 for primiparas and 15,270 for multiparas. In the third stage no further changes in the counts occur. The white blood count returns to normal by the seventh day post partum.

Other factors may contribute to variations in white blood counts. Fatigue may cause a slight rise. Paroxysmal tachycardia is accompanied by leukocytosis during the period of increased heart rate, but when the heart rate falls the white blood cell count promptly returns to normal. Emotional disorders characterized by fear, agitation and anger are often accompanied by leukocytosis which seems to parallel roughly the intensity of the reaction; with subsidence of the emotional crisis the leukocyte count returns to normal. Excitement alone, without the stimulus of activity, does not affect the leukocyte count. Leukopenia may result from prolonged dietary deficiency; however, a continuous restricted diet, sufficient to achieve a 10 per cent weight loss, results in no significant change in the leukocyte count aside from a slight reduction in the neutrophils. With fasting, leukocytosis gradually increases, reaching its peak on the third day (12,400), decreasing to 8,400 on the fourth day; there are slight variations until the sixteenth day, when the normal count is once more observed. In short, starvation and fasting produce no significant changes in the white blood counts.

Whether or not digestive leukocytosis occurs remains a subject of controversy. It would seem to be the consensus of most observers that the daily variations in leukocyte counts are not dependent on digestion.

Heat and intense sunlight may produce a transient increase in the leukocytes, especially in lymphocytes and eosinophils. Fever therapy reduces the leukocyte count within the first or second hours of treatment due to a reduction in the neutrophils. By the sixth to eighth hour the white blood cell count returns to about 80 per cent of the initial figure. The maximum

leukocytosis occurs several hours after the temperature has returned to normal and may be as high as 22,600, the increase being composed chiefly of nonfilamented neutrophils. This rise may be due to stimulation of the bone marrow but more likely to the acceleration of the circulatory rate accompanying hyperpyrexia, which is said to increase the velocity of the blood as much as 400 per cent. High altitudes are responsible for a relative leukocytosis, but it is difficult to exclude the additional ultraviolet radiation common to such altitudes as a causative factor, since this too is believed to stimulate a relative lymphocytosis. Changes attributable to high altitude and increased sunlight are,

however, only slight deviations from the accepted normal.

Average white blood counts are higher in the winter than summer, but fluctuations are greater in summer. In normal persons a period of increased systolic and diastolic pressures is followed by an increase in the white blood count, the increase consisting chiefly of neutrophils and eosinophils. The height and extent of seasonal variations is said to be influenced by constitutional habitus, viz., the pyknic individual has the high level and greatest range of fluctuation, while the sympathetocotonic exhibits the lowest level and narrowest swing of fluctuation.

F. C. FISHBACK, M.D.

THE NEED FOR YOUTH

During a recent discussion of the present and the future of medicine, a young physician said: "Why don't medical societies and the leaders of medicine act constructively to meet the needs of the day? The older men run things. We younger men look to them for action."

Whether older men can or will provide such leadership is a question. At times they have done so. In the nature of things, time inevitably brings about change. With a few notable exceptions older men commonly gauge situations in the light of a time before the present. Younger men are more alive to current influences.

In this column last year appeared an analysis of the ages of the members of the House of Delegates and officers of the American Medical Association.¹ The average age of the House of Delegates was 59.4 years and of the Board of Trustees 63.1 years. That article stated: "It would be interesting to know how this compares with the average age of boards of directors of important and active corporations." The trend in corporations has been toward younger and more active men.

There is some doubt whether the younger men can or should look to men in the upper age group for action. After all, their economic security has largely been attained if it ever will be. The changes now in process cannot affect them or their patients for very long. But the care of the sick and the future of medical practice is now and will for many years be a major interest of physicians who are now young.

Fortunately, there has been a very greatly awakened interest on the part of young physicians who have been in the armed services. Whether from their necessary administrative activity or from their fear about what may happen at home during their absence, they have shown, both by their letters and their activity, a renewed enthusiasm for being in and a part of any changing situation. Some of them after discharge or when assigned in their home areas have been observed to be quite active and vocal. This is a healthy sign.

In our local society, some younger men have been willing to give time toward making the Society's efforts effective on the local and national scene. Certainly more are active than formerly. Many others, however, have not seen

¹ Editorial: *M. Ann. District of Columbia*, 1944, 13, 344.

the importance of their personal participation in committee work, in voting, and in making their views felt. Especially do they fail to read the material in the *MEDICAL ANNALS* and the *Journal of the American Medical Association* in order that they may be fully informed as to what is going on

in the medical world as a basis for opinion and action.

It is to the young men one must look for ideas; the young men have the enthusiasm; they have the stamina for study and sustained activity. Youth is needed.

H. P. R.

In and Out of Focus

BY THE OBSERVER

Our Veterans Coming Home The war is at an end. Our service physicians will soon be coming home in increasing numbers. Their fine record entitles them to all the assistance we who have remained at home can give them.

Quite a number have dropped into the Medical Society's office in the past few weeks. Some were on leave, others were going on to other assignments. With regard to the latter group, their orders may be changed due to the war's end. Naturally, all of them are counting on our aid when they return to civilian life. We must not disappoint them. That would be unforgivable.

It has already become evident that many of their problems will be difficult to solve. Last month in this column your Observer called attention to the fact that offices for rent in downtown Washington are virtually non-existent. Recently the Secretary of the Society informed the press of the difficulties which were being encountered by service physicians who have returned. The resultant publicity aroused some public interest. Most of those who wrote the Society or called its office had something to sell. With few exceptions, the properties were unattractive or the prices too high. Rentals on the two or three offices recently vacated were exorbitant.

At the time this is written, it is hoped that

Government war agencies slated to go out of existence will soon give up their offices. Foreign governments have also taken over buildings which should be relinquished in the near future. In the meantime, members can assist by sharing offices and keeping the Society's office informed of vacancies. Then, too, Medical Center's new office building should be under construction before long. These possibilities will be closely followed up by the Society's Committee on Service Physicians.

Inquiries about locations have been received from physicians in the armed forces. Except for those who plan to engage in a specialty, this is not too important. General practitioners are needed in most parts of the city and its suburbs. As to the specialties, there is a distinct shortage in certain fields. Specialists or general practitioners, they will be welcomed by their colleagues in civilian practice.

In regard to postgraduate education, applications must be made by discharged medical officers to the Veterans Administration. Enrollment forms can be obtained at the Society's office. Discharged service physicians who wish to take a refresher course can do so either in a medical school in Washington or elsewhere providing the institution is on the Administration's approved list.*

* A detailed list of postgraduate continuation courses for veterans and civilian physicians appears in the *J. A. M. A.* for July 7, 1945, page 751.

With respect to hospital staff appointments, the Society has been informed that returning service physicians will be restored to their former positions. This is exceedingly important and will boost their morale considerably.

Those who desire to do so may become members of MEDICAL BUREAU. Alternate Listing Service will be given returning service physicians for a period of six months without charge.

The Secretary of the Society will be glad to be of personal assistance at any time.

These are just a very few of the things that the Medical Society is or contemplates doing for its members who have been in the armed forces. They will demonstrate more effectively than anything else that we are sincerely glad to have them home again.

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*Service
Above
Self*

There has been a tendency on the part of both medical and lay writers in recent years to debunk the old family doctor.

Scientifically, he may not have been all that he should have been. But he was long on common sense and understanding of human nature. Millions of men and women now living are not only grateful to him but revere his memory.

Mark Sullivan, the famed Washington columnist and author, is one of the vast number of those who look affectionately upon the doctor of another day. On August 6 under an Avondale, Chester County, Pa., dateline, he writes about the Doctors Ewing who served that community for eighty years. Father and son administered to three generations. The son, who died two weeks previous to Mr. Sullivan's dispatch, had brought 6,000 children into the world. The arrival of most of their parents had been attended by the father.

"In terms of time," Mr. Sullivan writes, "the combined practices of father and son spanned half America's history as a Nation; in terms of medicine they spanned the whole era of modern science. When the older doctor began practice here in the 1870's, tuberculosis was still consumption. Rheumatism had not become

arthritis or neuritis. Much of what is now called tonsillitis was 'quinsy.' Antitoxins and serums were unknown. Vaccination for smallpox already was practiced, in this community by a scab from neighbor's scar. For simple ailments, patients were given 'something to move the bowels,' often called a 'physic.' Appendicitis was 'inflammation of the bowels,' and usually fatal. Calls for the doctor came not by telephone, for there were none, but by a member of the stricken family or a neighbor who hurriedly saddled a horse and rode hard to bring word of emergency, sometimes on a remote and lonely farm."

Young Doctor Ewing's training came at a later date. He received the best, but returned to take over his father's practice in the small community from which he came. Speaking of him, Mr. Sullivan says: "Conscience was strong in him. He always remembered a parting admonition from a professor at the medical school, who told him, never take a chance of making a mistake, or you may go through life with an accusing tombstone always facing you on your path. He would go just as far as he knew the way, then send to Philadelphia for specialized experience."

As it does to all men, death came to Dr. Ewing as he was nearing 70. The war had placed new burdens upon him, 11 out of 20 doctors having gone into service from the southern end of the county. "Patients in this early-rising community," Mr. Sullivan continues, "were at his office before 6 in the morning, others late at night. Calls to the bed-sick came at all hours of the 24. He recognized the strain on him, tried to nap a few minutes at midday and in the early evening. Presently, attending his last confinement, as the new life came in, his went out."

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Announcement by the
The AMA's New Program A.M.A.'s Council on Medical Service and Public Relations of its "Constructive Program for Medical Care" was no great cause for jubilation in so far as your Observer is concerned. He appreciates

the fact that this new "platform" is more liberal than the one previously adopted and that is encouraging. But there is still no evidence that the Council intends to do more than adopt programs, platforms and principles.

Your Observer would like to know how this new program is to be implemented. Will the Council actively endeavor to make it a living thing? When will the expert on prepaid medicine, authorized more than a year ago by A.M.A.'s House of Delegates, be employed? If and when he is employed, will he be given sufficient authority so that his services will be of greatest value to medical societies? Although these important questions still remain to be answered, there are some clues as to what we might expect.

The Council puts out a newsletter which is sent, among others, to editors of state medical journals. In its July 23 issue the *News Letter* comments on the new program as follows:

"Here's your 'Constructive Program for Medical Care.' The Council suggests that it be used as a basis for an active, positive program by each state medical organization. It might be broken down point by point, with certain additions to meet specific community needs, and assigned to committees already existing or to specifically appointed committees for study and action. Don't expect the job to be done overnight, for results must come largely by trial and error; by evolution, not revolution.

"The 'Constructive Program' is not a complete answer; it isn't even a detailed answer; it's not a blueprint; it's not the ultimate result, but it is the map by which efforts can be charted, a framework and platform within and upon which to build a program of medical care that will be correlated eventually into a great health movement, national in scope, local in control.

"Some of the fourteen points are reminiscent of former American Medical Association platforms, statements of principles, resolutions. These were forward-looking, progressive, genuine, sincere statements, but too often never were applied in too many communities.

"That must be different this time. It is the duty and obligation of the medical organization and the citizens of each community to see that health rates an A-1 priority. The Council hopes from time to time to be able to give encouragement, aid and whenever possible definite guidance to make these principles live.

"In the Army they say 'activate.'

In Washington it's 'implement.'

In business it's 'expedite.'

But in plain, everyday American, it's 'Let's go!'"

This is an excellent pep talk. With a good part of it we agree. But the *News Letter* is right when it says the program is "reminiscent." Yes, it is reminiscent of the adoption of similar programs followed by inaction. We can only hope it will be different this time.

There is no substitute for the leadership that is needed. Needless to say, it would be welcomed by the Medical Society of the District of Columbia, for our society, like the others, would benefit immeasurably if its national organization were actively furthering a sound national health program.



The Hospital Chaplain

The Reverend George Ossman, Chaplain of the Medical College of Virginia hospitals, describes his duties and responsibilities in the July issue of the *Virginia Medical Monthly* in a most interesting manner. His presence in the College's hospitals, Mr. Ossman says, "is now taken as much for granted as that of the doctor or nurse. He is a regular member of the staff." Trained at the Massachusetts General Hospital in Boston, in the Institute of Pastoral Care, Mr. Ossman is familiar with the patients' needs and the doctors' desires. He also understands hospital routine and is trained to work as an orderly in an emergency. His work at the College is supported by the Interdenominational Religious Work Foundation of Virginia.

"The chaplain's day begins at nine," Mr. Ossman writes, "when he checks in to take care of his desk work. He must first get the new list of admittances of the previous day and night in order to decide whom to see. Next, he must check his mail and take care of communications with families of out-of-town patients and patients who have left the hospital but want his advice. He then looks over his records. He keeps a record of every patient he sees in order to follow through each day with a constructive visit.

"He looks over the work left by his assistants . . .

"Phone calls come in from supervisors or nurses for him to see special patients. Students or hospital employees find him helpful and come to him freely for all sorts of advice.

"At ten-thirty, the chaplain finally gets started on his rounds. First he sees the cases he considers most important and then routinely he goes from floor to floor. He can not see all; he tries to see those who he knows need him and always to check on those from out of town.

"This morning he must see a young boy from the country who is being treated for brain tumor. He finds him very weak and nauseated. The chaplain knows how rushed the nurses are, so he holds the child's head, wipes his mouth, and puts in a call for a nurse. The boy sinks back on the pillow exhausted, opens his eyes and looks up, then with a wan smile whispers, 'Oh, it's you—thanks.'

"In the next room he talks at length with a woman who is dreadfully worried about her family at home and the expense of the hospital. He helps her think her problems through. When he leaves, she is not so wrought up, and he promises to see her again soon.

"On another floor, a nurse comes to him to say that a patient he has seen before is dying. He goes right in and stays as long as the woman is conscious. Members of her family have been sent for, but they have a long way to come.

"On the wards he must stay long enough to speak to everyone. Frequently he uncovers difficulties which when known can be alleviated by the medical social workers with whom he is in close touch.

"He never feels that he has seen as many patients as he would like, but his time is limited.

"Whenever a patient is desirous of seeing a priest or rabbi of his own denomination the chaplain has an arrangement with clergymen in the city who will come when called. The chaplain tries to see all patients who want him regardless of race or creed."



New York
Plan Stalled Observer that the highly publicized Health Insurance Plan of Greater New York has not begun to function. A tremendous amount of time and effort is involved in such an undertaking, even where there is no opposition. In this instance, it appears that the physicians are none too enthusiastic, although medical societies of New York City are coöperating. The *American*

Journal of Public Health in its June issue comments on the failure of the Plan to begin operation as follows:

"A little over a year ago (April 30, 1944) announcement was made of the formation under the laws of the State of New York of a corporation called 'Health Insurance Plan of Greater New York,' to provide 'medical care and attention in any or all of its branches through duly licensed physicians, as well as nursing and other auxiliary services, together with necessary appliances, drugs, medicines and supplies.' Many who heard this announcement with satisfaction have been disturbed at the delay in the execution of the plan; but this delay has been necessitated by the importance and the difficulty of finding the right administrative leadership and of working out the details of providing service. The program is likely to be launched within the next few months; and the care taken in perfecting it will be found to be well warranted."

There are undoubtedly many among the readers of this column who are not familiar with the Plan. They will find the following description of interest.

"The plan, which has been prepared after extensive conference with the medical profession, with industry, and with labor, will be administered by a Board of 24 Directors, of whom 8 will be physicians. Under this general administrative body, a Medical Control Board of not less than 7, nor more than 15, physicians 'will have complete authority in matters relating to medical practice, science and ethics.'

"Subscribers will be enrolled as groups of employees. Each group must include 50 or more persons, and 75 per cent of the members of each group must enroll. The upper limit of family income will be \$5,000. Dependents (wife or husband and children under 18) will be covered by the plan.

"Coverage will include physicians' services in home, doctor's office, and hospital, as well as diagnostic and consulting services, with the exception of chronic functional and nervous disorders, sanatorium and other institutional care, cosmetic surgery or electrolysis, conditions covered by the Workmen's Compensation Law and those resulting from service in the Armed Forces. Hospital bills will be included in the total premium under a contract with the Associated Hospital Service of New York.

"The plan will be financed by a payroll deduction amounting to about 2 per cent of the workers' income, supplemented by a similar contribution from the em-

ployer. The city government (with some 175,000 employees) has agreed to enter the plan as soon as it is inaugurated, and an effort will be made to secure an equal number of enrollments from private firms and their employees. The 2 per cent of employee contribution is estimated to be about what the average New York wage earner is now paying for inadequate medical care. The program as outlined would provide a total of about \$75 a year per employee, or about \$33 per individual covered (including dependents). This would allow over \$20 for physicians' charges—nearly double the estimated return to the profession from the wage-earning group today.

"The program as originally outlined visualized two alternative plans of rendering service, an open-panel plan on a fee-for-service basis, and a plan of group practice on a capitation basis. After exhaustive consideration of these two possibilities, outstanding leaders of the county medical societies, as well as industrialists and labor representatives, have become convinced that the open-panel fee-for-service plan would inevitably be doomed to failure; and the present trend is toward the development of voluntary group practice units, affiliated with local hospitals, in out-patient centers each serving about 20,000 people. Such a program would make possible a capitation basis of payment, which is the only practical one; and, on the other hand, would insure to the physician an assured income from the start and opportunity for professional and economic advancement."



... *There Is No Freedom of Speech...* Newspapers thrive on controversy. Extremists in the medical profession have not hesitated to take advantage of this fact. Certainly Dr. Ernest P. Boas, Chairman of the Physicians Forum, is no exception. Recently he burst into print with an attack on the American Medical Association for its opposition to the Wagner-Murray-Dingell bill. He charged that the Association "is itself trying to regiment physicians into an isolationist and anti-social attitude on the important national issue of health security."

He was particularly perturbed because the new program announced by the Association makes no reference to "the bill for extension of social security, hospital construction, child and maternal welfare, disability insurance, and promoting medical research."

Dr. Boas has voiced similar views on other occasions. Recently, however, he gave them a new slant. In a communication appearing in *New York Medicine*, official publication of the Medical Society of the County of New York, he accused the *Journal of the American Medical Association* with failing to publish views in opposition to the Association's stand on social legislation. He charged also that the *Journal* distorted the facts. He declared, "...there is no freedom of speech in the medical press." To which Dr. Morris Fishbein is quoted as retorting that the A.M.A.'s Board of Trustees "never directed me to make the *Journal* a soap-box" for Dr. Boas. He said the prestige of the *Journal* was "not achieved by allowing socialistically and communistically inclined groups to acquire publicity far beyond their merit."

"There are a few hundred physicians in the United States," he continued, "associated with the Physicians Forum who urge complete socialization of medicine with Federal control through taxation. The amount of publicity they receive is out of proportion to their members, influence or the good they do."

That is a pretty good statement. However, it is true that most medical publications have been reluctant to publish articles unfavorable to the position taken by their respective organizations. Only recently a few have liberalized their columns, publishing opinions on both sides of the medical care controversy.

Your Observer is proud of the fact that the MEDICAL ANNALS has been, and is, free. Both sides of controversial questions have appeared in our publication. This is the democratic way. If we cannot withstand arguments favoring changes in medical practice to which we are opposed, our plight is indeed sad. Dr. Fishbein is right, however, when he objects to his publication being used as a "soap-box." It is certain that Editors of the MEDICAL ANNALS would also refuse to permit their journal to be used in this manner.

But it is a serious mistake to close medical journals to opinions with which editors or their organizations are in disagreement. For it is only through a free exchange of ideas that sound progress will be made.



Medical Care for Veterans All evidence points to the fact that our veterans' hospitals are in need of a drastic overhauling. And it appears that that is just what they are going to get when General Omar N. Bradley, the new Administrator of the Veterans Administration, gets hold of things.

Medical journals still continue to have their say on the subject. The *New England Journal of Medicine*, in its August 9 issue, editorializes as follows:

"The failure of the people of the United States in the past to provide the best of medical care for veterans is inexcusable. It has been argued that such care should be limited to conditions or diseases directly or indirectly attributable to military service, but in many cases the line of distinction is difficult to draw and if there is any question the veteran certainly deserves the benefit of the doubt. Furthermore, it seems reasonable that medical and hospital care should be furnished for all veterans, without regard to the cause of their illnesses or disabilities. Now that thousands of wounded are being returned to this country, to be discharged to the care of the Veterans Administration after a certain period in Army and Navy hospitals, its facilities become of increasingly great importance, particularly since there is a possibility that the program will be extended to include the care of their dependents.

"The Veterans Administration was created over twenty years ago, and in the intervening period, hundreds of millions of dollars have been turned over to it by Congress for the construction of hospitals, their staffing and their maintenance. In other words, the necessary wherewithal has been provided. Unfortunately, however, this type of medical practice has failed to attract the most competent of the medical profession.

"Undoubtedly one of the reasons for this lack of appeal is the fact that physicians of the Veterans Administration are under the control and supervision of men with relatively little knowledge regarding medical matters. Three bills now before Congress (H.R. 3310 and 3317 and S. 1079) propose a department or bureau

of medicine and surgery within the Veterans Administration.

"Reorganization of the medical personnel along such lines would eliminate some of the difficulties of the past . . ."

Dr. W. Wallace Gill, guest editorialist in the August number of the *Virginia Medical Monthly* comments:

"... Some remedies have been advised such as elimination of most of the paper work, the appointment of an outstanding medical man as top authority (he should not be over 55, senility has been pointed out as one of the defects of present staff), adequate pay to attract men of ability.

"Now, how are the staffs of the various facilities to be rejuvenated, kept alert, and informed? By reading medical literature and attending postgraduate courses? No! that will not work! I suggest a visiting staff selected by the faculty of the nearest medical college made up of key men in the various departments such as medicine, surgery, orthopedics and psychiatry, each chief to be accompanied by a resident, or equivalent, actually to oversee or carry out staff orders, while staff remains at the Facility. Visiting staff should consist of not less than eight men—should remain on duty at Facility not less than two weeks. They are to consult with the permanent staff, but the opinions and directives of the visiting staff will be put in effect. This setup will have the effect of a refresher course applied on spot.

"Also, and not the least important, the visiting staff and not political overlords shall determine, from performance, just who shall be promoted and just who shall be retired. These staff visits should be made not less than twice a year. I believe that the medical colleges will cooperate in such a plan by granting leave to such staff men for the performance of this essential service to our disabled veterans. They are entitled to the best and under the present system are not getting it. Only by continuing contact with teaching staffs of our outstanding medical colleges can the permanent staffs be kept abreast the progressive march of medical science. I am not suggesting that colleges 'lend lease' these staff men to the government but that they be compensated adequately."

The *Journal of the American Medical Association* has also been critical of veterans' hospitals.

"Many theories have been offered as to just why medical care of the veterans should reach a low state."

the *Journal* observes. "The majority opinion seems to tend toward the concept that the nature of the system whereby the medical staff is chosen and whereby its administration is developed, and the conditions under which the medical staff serves, are the factors chiefly responsible . . ."

"Perhaps the time is ripe for a really authoritative, independent investigation of the administration of medical service to veterans, made by a committee responsible directly to the executive office of the President."

It would seem that a study of the whole situation should be made by qualified experts. This is the purpose of legislation recently introduced by Senator Henrik Shipstead of Minnesota. Once the facts have been determined, there is no doubt that General Bradley will take steps necessary to place veterans' hospitals on an equal footing with other hospitals of the country.



**"I Can See
Little Mayo
Clinics . . ."**

Henry J. Kaiser is an astonishing person. Primarily a business man, he has many and varied interests. In fact, one wonders how he finds time to give them more than superficial attention. But Kaiser is not an ordinary individual. What he does is done thoroughly. He may be ill advised or mistaken at times but no one doubts his sincerity. Nor is there any question as to his remarkable abilities. He has been and is a doer on a grand scale.

Taking over Drew Pearson's Merry-Go-Round for "a free ride" on August 20, guest commentator Kaiser outlined a four-point post-war program. It was no surprise to those who know him that health was given priority over the other points. He has long visualized a healthier America and believes it can be done through the competitive system. Whether doctors agree with his ideas or not, Kaiser gives them something to think about.

"At the invitation of the Pepper Committee of the Senate," Mr. Kaiser writes, "I have drafted a bill for

Federal legislation to achieve competitive health. This bill has in mind the future and the hopes of the half million veterans of war who are going to come home—not only doctors, but nurses, pharmacists, and battalion aid men. It would empower the Federal Housing Agency, which has financed the ownership of nearly a million American homes, to guarantee 90 per cent of local bank loans to build and equip hospitals. This financing would be made available to groups that undertake to provide prepaid medical care.

"Here is an opportunity! In the armed forces, doctors have learned to work and live together in group practice. Under the bill, they could invest the funds set up for them by the GI Bill of Rights in their own group practice clinics at home. Together, ten of them could make up a pool of \$25,000 and get a loan of \$250,000 to set up much needed medical facilities.

"I can see little Mayo Clinics springing up all over the Nation. Founded on the sound economics of prepaid medicine, these clinics would operate as going business enterprises, competing to reduce their cost, improve the quality and expand the scope of their service to the public.

"Medicine has a vast market awaiting it in the half of our population that today receives inadequate medical care or no medical care at all. Prepaid competitive medicine, backed by adequate facilities, can reach that market immediately. Construction and operation of the facilities would provide employment—let me be specific—for three million men and women."



**Who Starts
Malpractice
Actions?**

The advice which your Observer has given most frequently to young physicians is "Don't practice a day without malpractice coverage." Whether he be right or wrong, no physician is safe from malpractice suits. This is something which needs to be impressed not only on the neophyte in medicine but on older practitioners as well. There is a surprising number of the latter who are not protected against claims for damages. Perhaps an examination of the causes of malpractice actions may arouse this group to the fact that they are courting disaster.

Dr. Louis J. Regan, a physician who holds a Bachelor of Laws degree, has written an enlightening article for *California and Western*

Medicine entitled "Malpractice Actions: Who Starts Them?" Dr. Regan says about the origin of malpractice suits:

"There are many unsolved problems in medicine. There are many conditions the cause of which is unknown. The importance of removing or controlling a causative factor is axiomatic.

"In respect to malpractice we do know the precipitating cause. Almost every malpractice claim is instigated by a physician. That may seem to be a harsh statement but it is the truth. Unethical and destructive criticism by one physician of the professional care rendered a patient by another physician is the cause of most of the unjust malpractice accusations. Such criticism acts as a sort of virus which implanted in the mind of the patient produces, after an incubation period of varying length, the inevitable result.

"We know the chief cause of this plague. However, the cause is not easily controllable. It seems that to refrain from criticism is almost beyond the power of some of us. Why is it that physicians are so prone to criticize their colleagues? There appears to be no simple answer to this question. There is no denying the fact, however, nor that the effects are deplorable.

"It is not suggested at all that any physician should conceal or cover up an instance of actual malpractice whether on his own part or on the part of another physician. But that is not the point we are considering. The important questions to ask ourselves now are: can any physician fairly and ethically criticize the work of or the result obtained by another physician until and unless he is in possession of all of the facts of the case? Must he not have the story of the physician as well as the patient's story?"

Dr. Regan lists as contributing causes of malpractice suits the following:

1. Failure of the physician to exercise tact in his contact with the patient and the patient's family.
2. Charging excessive fees.
3. The use of irritating fee collection methods.
4. Making overoptimistic prognoses, promising too much to the patient.
5. The failure to prepare the patient for reasonably to be anticipated anatomical, cosmetic or functional defect or deficiency.
6. The delegation of duties to poorly qualified assistants beyond their capacity to perform.
7. The physician absenting himself without notice to his patients, and without arranging to have a well-qualified substitute available.

8. The failure to have a consultant see a patient who is complaining of his care or progress.

9. The making of statements which can be construed as admissions of fault.

10. The physician telling the patient that he has malpractice insurance coverage.

11. The failure to warn the patient against his unwise course when he does not follow advice, or discontinues treatment before he should.

12. The undertaking to treat cases not well within the physician's experience and understanding.

13. Failure to secure consent to operation and for autopsy.

14. Failure of the physician to keep abreast of developments in his profession.

15. Utilization of procedures of an experimental character.

16. Failure to employ X-ray and clinical laboratory facilities in diagnosis and in treatment.

17. Failure to exercise ordinary care in maintaining plant and equipment in a safe condition, and

18. Abandonment of the patient."



"Over the Horizon . . ." An address given by Thomas Parran, Surgeon General of the United States Public Health

Service, at the dedication of the Health Institute, established by the United Automobile Workers, C.I.O., at Detroit in January of this year, has just come to your Observer's attention. Copies of it have apparently just been mailed to those on the Public Health Service's mailing list.

Recognizing labor's potency, Dr. Parran makes a strong plea for the expansion of public health and hospital facilities. He also has something to say about medical care, offering suggestions which your Observer feels certain will be of interest to readers of this column.

"On the horizon of social progress," Dr. Parran says, "we see the expanding field of public health and labor's participation in our national life. In recent years, organized labor has learned that higher wages cannot purchase the many community, State, and national services which all of us need to live healthy, productive lives. The unions are taking an increasingly active part in supporting health and social welfare services throughout the Nation; they are becoming more aware of what is needed to insure to every individual equal opportunities for health. At the same time, the public

health professions, in their close contacts with the human crises of birth, pain, and death, have broadened and sharpened their knowledge of what is needed to relieve suffering, prevent death, and raise the health level of all our people.

"Labor already has recognized its stake in a national medical care program. It is not, perhaps, as fully aware of its share in the broader plan to insure maximum health services to all the people. To realize this plan, a number of objectives must be reached. In addition to medical care, we must also provide in every community enough hospitals, diagnostic clinics, and health centers, all giving a high quality of service. In particular, we must increase the amount and scope of public health services to prevent disease. We must train doctors, dentists, nurses, laboratory technicians, and other health workers in sufficient numbers to do the job. We must support more scientific research in the health and medical fields so that we may continually add new knowledge for the promotion of health and for the prevention and cure of disease. We must make sure that every family in the country has decent housing with safe water and adequate sanitary facilities.

"So vast are our national health needs that no one group can meet them. It will take the best thought in the Nation; the combined effort of all citizens involving the complete coöperation of all groups. I do not believe that we shall achieve an effective national health service without difficulty, without delay, or with complete harmony. But I believe it can be done. This is the challenge before every American today."

Dr. Parran's views on health insurance are pretty well known to the medical profession. However, they bear repetition.

"It is obvious that the financing of medical care of the individual, as a part of the program for total health care should include some arrangement for prepayment," Dr. Parran observes. "The occurrence of disease is sporadic. The heavy cost of catastrophic disease falls unpredictably and unevenly upon the population. For the individual family, I believe that these risks should be met on a national basis, either through insurance, or through public taxes, or preferably, through a combination of both. Social insurance thus can contribute to the advancement of national health by spreading the cost of illness and by providing the wage earner compensation in lieu of wages when he is ill and unable to earn.

"Social insurance in itself, however, no matter how inclusive, does not constitute a total health program, but is part of it and contributory to it . . ."

Dr. Parran is a tenacious, able fighter for any cause he espouses. His quiet, shy manner is misleading to those opposed to the beliefs which he holds. Regardless of what the doctors think of him Dr. Parran has strong public support.

Your Observer has long felt that Dr. Parran is a better friend of the medical profession than many physicians are willing to concede. He believes that a closer and friendlier relationship between the United States Public Health Service and the medical profession will go a long way toward making inevitable changes less trying for all concerned.



Birth Registration

Doctors are notoriously averse to doing paper work. Even reporting of communicable diseases, births and deaths which usually involve a moderate amount of time and effort, it seems, is burdensome. But the laws provide that these reports must be made. Usually there is a penalty for failing to do so. Despite this fact, many physicians do not comply fully with legal requirements. Fortunately public officials have been lenient.

The Health Officer of the District of Columbia recently appealed to doctors, requesting them to complete birth certificates. He asked that the following statement be published in the **MEDICAL ANNALS**:

"The District of Columbia has established a good record for the registration of births, but physicians frequently fail to report the name of the child on the birth certificate. In 1944, out of a total of 22,856 registered births, the name was omitted on more than half of the birth reports received from physicians. This omission not only required the Department to write follow-up letters to the parents, but caused unnecessary delay in the payment of servicemen's dependent allotments and in the issuance of ration books."

Now doctor, busy as you are, you can do better than that. Let's give our Health Officer a hand.

Washington Physicians of Yesterday



ELISHA CULLEN DICK, M.D.

Among the Washington physicians who played an important role in the early history of our country is Dr. Elisha Cullen Dick. Born in 1750 or 1752 (his biographers are not certain as to the exact year), in Chester County, Pennsylvania, he was for a long time a resident of what was then Alexandria, D. C. He graduated from the University of Pennsylvania in 1782 and began practicing in Alexandria in the same year. While at the University, he studied medicine with Drs. Benjamin Rush and William Shippen of Philadelphia.

Dr. Dick was one of the founders of the first Masonic Lodge in Alexandria, chartered in 1783, of which General George Washington was Worshipful Master. After Washington's retirement in 1789, Dr. Dick succeeded him as Master.

When the cornerstone of the Capitol at Washington was laid, in 1793, Dr. Dick marched arm-in-arm with President Washington and took part with the latter in the ceremonies.

One of the two consulting physicians, Dr. Dick attended Washington in his last illness. He remained with the patient during the last hour of his life, striving with his colleagues, Drs. Craik and Brown, to save him.

According to his biographers, "the historic events with which he was so prominently associated directly connect the Medical Society of the District and the profession of medicine with several of the most noteworthy and conspicuous occurrences in the foundation and early history of the District."

Dr. Dick died September 22, 1825.

Military Affairs

BRINGING SURGERY TO FRONT LINE TROOPS

SERGEANT JOSEPH DUBÉ

Marine Corps Combat Correspondent, formerly of the New York City Bureau, United Press

OKINAWA (*Delayed*).—Bringing the mountain to Mahomet best describes the most successful mass treatment of wounded Marines practiced in the Pacific war.

The idea came to Navy Captain Don S. Knowlton (M.C.) when he was training the medical department of the Sixth Marine Division for the Okinawa campaign. It was daring. It might prove costly in equipment and in lives of medical men. But he organized and experimented, and succeeded in bringing surgery to front line troops—rather than lose the time to bring wounded troops to rear-based surgery. Dr. Knowlton refers to his system as “leapfrogging” to the front line.

It has brought every medical unit, including the division field hospital, much closer to the fighting than ever was attempted before. The medical company now is often within 200 yards of the fighting Leathernecks.

The campaign was marked by bloody battles for the men of Major General Lemuel C. Shepherd's Sixth Marine Division. Sugar Loaf Hill, Crescent Hill and Charlie Hill are a few of the fights Marines entered knowing that they had no more than an even chance of walking back. Still they drove on, aided by the knowledge that the finest surgical skill and most modern equipment were within calling distance if needed. As the campaign raced to its climax, the defeated enemy seized its last straw by screaming of terrible American losses.

Scareheads in American newspapers did little less to relieve anxiety at home.

Casualties were heavy but more important, particularly to relatives of the fighting men, is the fact that the mortality rate for the Sixth Marine Division has been less than one half of one per cent

of all wounded. Moreover, approximately one third of all casualties already have returned to active duty. Credit for this remarkable record lies squarely with Captain Knowlton.

A resident of Washington, D. C., where his wife, the former Margaret Peerce of Baltimore, Md., now lives at 1805 Hoban Road, N. W., the doctor is a graduate of Yale University and Tufts College

Medical School. He did postgraduate work at Yale at the New Haven General Hospital.

Since World War I he has been a Naval Reserve officer. Meantime, he taught at Georgetown University Medical School for 18 years, leaving with the title of Associate Professor of Surgery.

Captain Knowlton entered active service in this war in October, 1940, and became senior medical officer at the training center at Quantico, Va. He was with the Marines in the battle for Guadalcanal as assistant division surgeon. There he helped organize the first air evacuation of wounded in the Pacific area, subsequently earning the Legion of Merit.

In Okinawa, Dr. Knowlton's system of leapfrogging hospital units up to the battlefield has

THE WAR IS OVER BUT—

Although the war has officially come to a close thousands of physicians will continue to serve with the forces of occupation or will remain in the services pending the discharge of sufficient personnel to warrant their release. So in our opinion this is no time to discontinue the War Section. In fact it should and will be retained under the caption Military Affairs until a majority of our physicians have returned to civilian life.

THE EDITORS

relied on the independent efficiency of every man under his command to the corpsman at the side of Leathernecks probing enemy positions. And when the doctor mentions hospital corpsmen, it is in tones of reverence and awe. Of the 900 who invaded the island with Marines, more than 250 have been casualties.

"Corpsmen have the spirit of the Marine Corps," he says. "They realize that when they are with the Marines, their performance must be above and beyond the call of duty."

Most of the men assigned to him he knows by name. More than 75 per cent of the officers and men were graduated from the Medical Field Service School at Lejeune, N. C., which he organized after returning from Guadalcanal.

"They work in caves, ditches, defilades and in mobile surgical trailers which we built ourselves," he said. "They are able to treat wounds while they are still fresh. For the first time they have whole blood in ample quantities. These factors have combined to produce success for us."

Not as spectacular, but fully as important as battlefield surgery, has been the fight against disease. Preinvasion intelligence had labeled Okinawa a sewer ridden with malaria, dengue, leprosy, plague, typhus, filariasis and other skin diseases. But preventive measures produced a disease rate believed the lowest for the entire Pacific area. It is a minor fraction of one per cent.

An epidemiologic unit attached to the Sixth Marine Division started things off by introducing sanitation—virtually unknown to Okinawa. Mosquitoes, lice, flies and other vermin were brought under control by spraying DDT powder from torpedo bombers and manually from pack-sprayers, and by draining the thousands of shallow rice paddies that dot the island. The program is still progressing.

A native of Belfast, Maine, Knowlton is the son of the late Dr. Frank Adams Knowlton and Mrs. Isabel Knowlton, who now resides at Saco, Maine. To him the Marine Corps always has been the "varsity team." It's this spirit that impels his men to actions "above and beyond the call of duty," as it does their skipper.

SERVICE NOTES

Colonel Edward C. Morse and Captain Clyde Reeves, both members of this Society, were assigned to an Army hospital which in December, 1944 was cited for "outstanding performance of duty... especially for the period when operations in Southern France brought large numbers of Allied and enemy

wounded to them for treatment" The Meritorious Service Unit Plaque was awarded by order of A.F.H.Q. Colonel Morse was commanding officer of the hospital from the time of its activation in 1942 until recently. The hospital has also earned two battle stars during its overseas service.

LETTERS FROM MEMBERS IN THE SERVICES

From Captain Percy A. Bryant, c/o Postmaster, San Francisco, Calif.:

Dear Mr. Wiprud: I just received the newsletter of June 27 and enjoyed reading it very much. This letter will be twofold, first to thank you for the newsletter and next to tell you of my change of address.

Yes, I'm now at this General Hospital on Guam and the work is interesting but I must say all services are active and overworked. The casualties we get in this hospital are mostly from Okinawa. Some of the poor devils are in pretty bad shape.

I presume you have read more in *Time Magazine* about this island than I can possibly tell you. I understand it has gotten many writeups and pictures also. Let me say right

here, though, it's hot and rainy. That part they probably did not mention in *Time*.

The experience Dr. Lindsay had was one I would not like to go through. I know he was glad to get off with his life. When you learn about such acts being committed by service men, it gives a pretty good idea as to what is going to happen when . . . [the undesirable element in the Army] get back to civil life. They will be a long time adjusting and I have a feeling the incidence of crime will definitely increase.

The social life here at the hospital is nothing out of the ordinary. We have an Officers' Club now (tent) but very soon there will be a new one built, Quonset Hut, which will be bigger than the present one. Liquor and beer are rationed but we manage to pool enough to have a good Saturday night about every week.

I would like to be remembered to the men and the office force.

From Captain William D. Chase, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: I seem to keep your office busy changing my address on their mailing list, and now I have still another new one. It didn't take them long to get wise to me at my last station in India, so here I am being given one more chance—this time somewhere in China. The censor would be mad at me if I revealed my location any more accurately, but I understand it is permissible to say that I "flew the hump" over The Himalayas and saw some very beautiful and interesting country en route. The cool climate here is a welcome relief from the hot, sultry climate in India. Am assigned with the Chinese Training Command at the Field Artillery Training Center, but working for the most part with American troops in one of the dispensaries.

Have been receiving your regular newsletters from time to time and certainly have enjoyed and appreciated them.

From Lt. Comdr. Clayton B. Ethridge, c/o Fleet Post Office, San Francisco, Calif.:

Dear Ted: Well, Ted, I didn't stay long at Corona, California, before I was shipped out here to Pearl Harbor, Island of Oahu, Territory of Hawaii, where I am serving as consultant in cardiology on the hospital staff. It's a very good assignment and I like the setup. Lt. Commander J. R. McGriff is also on the staff, in otolaryngology.

I enjoyed very much receiving your newsletter dated June 27, and hope you will take cognizance of my new address to send along future editions of same.

From Lt. Colonel Elmer W. Fugitt, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: Over here in the quiet rural atmosphere of Southern England your newsletters from Washington very entertainingly bolster memory of life and friends in the old home town. Even though they invariably arrive between two and three months behind their date of origin, they are still very interesting. However, ballots for the Society elections, and requests for replies to specific questions by a certain date are hopelessly late.

Life here in England is amazingly quiet, nor was it any less so when the war was at its height. No excitement amongst the civil population; no rapidity of movement or accomplishment. That little Virginia town where Dr. Shull used to practice would seem like a roaring metropolis compared to most of these English towns, and it would certainly be far more advanced as regards to the . . . [modern conveniences].

My own work since arriving here in England has been largely concerned with the movement of casualties. I am glad to have had experience with air evacuation, which is a remarkably efficient method. In weight of numbers moved, and, of course, speed, it is far superior to any other means. It is certainly the method of choice. Last summer it was quite common to have casualties bedded down for definitive

treatment in a general hospital at 3 or 4 in the afternoon who had been wounded at 6 that morning at St. Lo.

From Lt. Colonel Edward J. Grass, c/o Postmaster, San Francisco, Calif.:

Dear Ted: I welcome your letters more than any other communications I get, except the ones from my wife. Am now at the northern tip of the Philippines and saw the ocean again for the first time in seven months. The battle here is about over with the exception of what they call "mopping up." It won't be long now before the actual invasion of Japan will take place. My guess is that the war will last at least another year.

All of the Docs I have spoken to believe there will be some form of socialized medicine. All of the Docs will take some sort of postgraduate work when they get out of the Army. Over 50 per cent will establish a practice elsewhere than their original location. Smaller towns 10,000 to 50,000 seem to be preferred. They are all worried more about the future than the present.

The prevailing diseases at present are amoebic dysentery, malaria, acute infectious hepatitis (jaundice). All of the Jap prisoners have malaria and over 75 per cent of the natives.

The point system is working very slowly and most of the veterans will probably be in on the initial Japan landing. We hear the meat rationing in the states is very strict. The soldiers over here get meat at least once a day.

It's hot here, like a 15th of July in D. C., 365 days in the year. The nights, however, are cool, fine for sleeping. There is no liquor here and haven't had a drink for six months.

That's about all for now, Ted. Keep the news rolling and we will all write when we can.

From Major Henry A. Grennan, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: Frank Cawley and myself are the only two Washington people in our hospital, which has been overseas for the past twenty months. We have had plenty to do most of the time and were set up in two locations in England before going to Normandy last July and coming to our present location in October.

We had some hectic days for awhile, especially during the "Bulge days" and the three months when the buzz bombs were falling on Liege. Nasty things buzz bombs!

In particular I want to comment about how well you are keeping us informed about the medical-economical situation and the various medical care plans being formulated and tried out at home. I believe when we eventually do get home we are going to be quite well informed and in an up-to-date way about these problems, thanks to you and to the other members of the Society who have our interests at heart.

We recently had a visit from Jim Greer, whom we enjoyed seeing very much. A few weeks ago I saw Bill Howard and "Ducky" Daughton in Paris. Both seemed to be keeping a little too busy to enjoy the capital life.

Our future is undecided upon at the present. The ETO is getting a little bit boring now, and it would be nice to see old friends in Washington again.

From Commander Elmer Klein, c/o Fleet Post Office, San Francisco, Calif.:

Dear Ted: Now that the P. O. Dept. insists on making our wants known in the form of requests for periodicals, I say, by all means, continue sending the *ANNALS*. It is good to know what the medical colleagues back home are thinking and saying. Its more personal expression of it, as well as your own reactions and observations contained in your overseas letters, has been even more helpful in spanning the many thousands of miles we are removed from home. Thanks for the faithfulness with which you have chased me all over the world.

Psychiatrists seem to have come into their own in this war, at least as far as plenty of work is concerned. It's a good thing, for the longing to be home would be too hard to bear without it—even for a psychiatrist. All our hopes and thoughts are directed toward that, especially now that chances for its early realization have improved so much. We all say it can't be too soon.

From Lieutenant (j.g.) William C. Manion, c/o Fleet Post Office, San Francisco, Calif.:*

Dear Mr. Wiprud: I arrived back at our rest area today fresh from the Okinawa campaign to find your interesting letter and news awaiting me.

It was indeed a pleasure to receive your letter. I am looking forward to meeting some of those men mentioned out here. Captain Don S. Knowlton, M.C., U. S. N., a District Society member, is our Division Surgeon. I'm sure that many members will be glad to know that he is all right and still doing a wonderful job.

Of course we are all looking forward to the peace. The eighty-four days of combat on Okinawa were very trying at times, but when one stops and thinks, despite its horrors, how much better we can handle the casualties now than in the previous war, we still have much to be thankful for.

From Lt. Comdr. Edward W. Nicklas, Norfolk, Va.:

Dear Ted: Sorry to have missed seeing you while I was in Washington. I would have enjoyed the opportunity of seeing you again and talking over many things with you. Bill Gill said you would be interested to learn that neither the people nor the majority of doctors in England particularly like their scheme of socialized medicine. Due to the very low income level of the masses, however, most of them are able to get medical care they otherwise could not afford. Most of the ones I talked to said that office consultations were very brief and usually consisted of a few questions and prescribing without any examinations. This, of course, did not apply to the well trained men, but to the general practitioners who do most of the panel work. Invariably people would say that they definitely would prefer better care on a fee system if they could afford it—and most of the ones who could pay

did so on the same basis that we enjoy here. I would like to tell you more about this, and will make a point of dropping in next time I am in Washington, which should be in a month or two.

I want to tell you again how greatly I appreciated your "newsy" and "homey" letters while I was overseas.

From Lt. Colonel Walter Stokes, c/o Postmaster, New York, N. Y.:

Dear Ted: Since I saw you last month during my brief visit to Washington I have been assigned to the Cazes Air Base at Casablanca, French Morocco. It is proving a busy and satisfying job for this is today the hub of air redeployment and the most active air base in the world. It is a deep satisfaction to have a part in what is going on here. I am director of ground training at the Base and have a widely varied lot of responsibilities, some of them new to me.

Recently I had a memorable experience in representing the Base at the Casablanca Bastille Day celebration. It was a spectacular demonstration, with the armed forces of many nations taking part. Afterward there was a reception at the villa of the French Governor—and the first real champagne I've tasted in many a day.

From Captain Robert G. Taylor, c/o Postmaster, New York, N. Y.:

Dear Mr. Wiprud: Having enjoyed your letters for many months over here, I have always wanted to write and express my appreciation. I am always delighted when it is time to receive another for I find them so interesting.

I am at present back in England waiting for further developments. However, I did spend a few interesting months on the Continent. We had a rather unusual but very interesting job of supervising German military hospitals. As various hospitals were captured, it was our assignment to take over from there and ascertain every detail concerning their capacity, types of cases, their staff of doctors and nurses, and their various immediate necessary needs. As you might imagine, it involved many things and we were free to carry out our work however we could. The one most interesting hospital that was assigned to us was a 2,400 bed S.S. Hospital. In the meantime it was a grand opportunity to observe first hand German military medicine, which certainly was not too impressive.

The only Washingtonians to my knowledge in this immediate vicinity are Lt. Colonel Lynn Cooper, Chief of Medicine at the 97th General, and Captain Willard Camalier at the 49th Station. I have been trying to keep in touch with as many as I know about over here, for it is always gratifying to see or to hear about someone from Washington.

I was interested in reading in your letter that you had been in "Dr. Benny Leonard's office" and saw Lt. Colonel Daniels. I had a very nice letter from Dr. Daniels recently, also Grennan, both of whom I was associated with before Army days.

* Applicant for membership.

THE WAGNER-MURRAY-DINGELL BILL (S. 1050)

The Wagner-Murray-Dingell bill differs in many respects from the previous one, some of which differences will be italicized or otherwise referred to in this and succeeding analyses. For one thing, it contains ninety-five more pages. Briefly and in broad outline, here is what the bill contains: It adds a new title to the Public Health Service Act for grants and loans for hospitals and health center construction. This title corresponds closely with the provisions of the Hill-Burton hospital construction bill, with significant exceptions. It provides for grants and services to develop more effective measures for the prevention, treatment and control of venereal diseases and tuberculosis and to extend and improve public health work. It proposes grants to states for maternal and child health services, for services for crippled children and for child welfare services. It would make available grants to states for public assistance to needy individuals, including medical care for such individuals. Section 9 proposes to amend title II of the Social Security Act to provide a national social insurance system. The amended title would provide for (a) prepaid personal health service, (b) a national system of unemployment and temporary disability insurance (including cash benefits for disability from sickness which causes unemployment), (c) retirement, survivor and extended disability benefits, (d) a national social insurance trust fund, (e) credit for military service, (f) extended coverage to include an estimated additional 15,000,000 persons, (g) contributions or taxes by employers, employees and the self employed and (h) certain general provisions to apply to the operation of the title.

Some of the foregoing parts of the bill will be dealt with in subsequent analyses. The present analysis will be confined to that section of the bill proposing a system of compulsory health insurance to be "made available to 135,000,000 persons," in the words of Senator Wagner. In passing, it is perhaps significant to note that the term "compulsory" appears in no place in the releases made available by Senator Wagner to explain the contents of his bill and to construe its provisions. Rather the emphasis has been placed in such releases on the contention that the legislation will not interfere with the normal relationship between the patient and his physician and on the point of view that the health insurance provisions will not be mandatory on the medical profession.

The national social insurance system will be financed in general from a trust fund established by a 4 per cent employer and a 4 per cent employee contribution on wages and salaries up to the first \$3,600 a year paid or received after Dec. 31, 1945. The first bill placed the ceiling at \$3,000 a year and the employer-employee contribution at 6 per cent each. The contribution to

be made by the self employed will be 5 per cent of the market value of services subject to the same ceiling limitation. The contribution by states and localities and by their employees will be 2.5 per cent of the first \$3,600. . . .

MEDICAL, HOSPITALIZATION, DENTAL, NURSING AND RELATED BENEFITS IN GENERAL

Part A of the amended title II proposes a system of compulsory prepaid personal health service insurance to covered employees and certain specified dependents. As used in this part, the term "personal health service benefits" is defined to include general medical benefits, special medical benefits, general dental benefits, special dental benefits, home nursing benefits, laboratory benefits and hospitalization benefits. There was no provision in the first bill for dental or home nursing benefits. When the term "general medical benefit" is used, it means services furnished by a legally qualified physician or by a group of such physicians, including all necessary services such as can be furnished by a physician engaged in a general or family practice of medicine, at the office, home, hospital or elsewhere, including preventive, diagnostic and therapeutic treatment and care, and periodic examination. The definition in the earlier bill did not refer to services rendered "by a group of such physicians."

The term "special medical benefit" is defined as necessary services requiring special skill or experience, furnished at the office, home, hospital or elsewhere by a legally qualified physician who is a specialist or consultant with respect to the class of service furnished, or by a group of such physicians, or by a group of physicians including such specialists or consultants.

* * * *

A beneficiary entitled to laboratory benefits will receive such necessary laboratory or related services, supplies or commodities as the Surgeon General may determine, including chemical, bacteriologic, pathologic, diagnostic and therapeutic X-ray and related laboratory services, *refractions and other ophthalmic services furnished by a legally qualified practitioner other than a physician*, physical therapy, special appliances prescribed by a physician, and eyeglasses prescribed by a physician or other legalized practitioner. If any of the services, supplies or commodities covered by this definition are provided a hospitalized patient, or by a physician or dentist incidental to services rendered, payment therefor will be included in payments for hospitalization or for services furnished, respectively.

* * * *

NATIONAL ADVISORY MEDICAL POLICY COUNCIL

The pending bill contemplates the creation of a National Advisory Medical Policy Council. This Council will consist of the Surgeon General as chairman and sixteen members appointed by him *without regard to the Civil Service laws and subject to the approval of the Federal Security Administrator*. The appointed members will be selected from panels of names submitted by professional and other agencies and organizations concerned with medical, dental and nursing services and education and with the operation of hospitals and laboratories and from among other persons, agencies or organizations informed on the need for or provision of medical, dental, nursing, hospital, laboratory or related services and benefits. A new provision in the bill requires the membership of the Advisory Council to include (1) medical and professional representatives and (2) public representatives, in such proportions as are likely to provide fair representation to the principal interested groups that furnish and receive personal health services, having regard for the functions of the Advisory Council.

Appointed members will hold office for four years, with terms of office staggered, and will receive compensation at the rate of \$25 a day for the time spent on official business with the Council plus actual and necessary traveling expenses. The Council will be required to meet not less frequently than twice a year and whenever at least four of the members request a meeting. The Advisory Council will advise the Surgeon General with reference to *questions of general policy and administration* in carrying out the provisions of this particular section of the bill, including (1) professional standards of quality to apply to personal health service benefits; (2) designation of specialists and consultants; (3) methods and arrangements to stimulate and encourage the attainment of high standards through the services of general or family practitioners, specialists and consultants, laboratories and other auxiliary services, and through the coordination of the services of physicians and dentists with those of educational and research institutions, hospitals and public health centers, and through other means; (4) standards to apply to participating hospitals, to the relations or coordination among hospitals and to the establishment and maintenance of the list of participating hospitals; (5) adequate and suitable methods and arrangements of paying for personal health service benefits; (6) studies and surveys of personal health services and of the quality and adequacy of such services; (7) policies and procedures for determinations of disability; and (8) grants-in-aid for professional education and research projects. Under the first bill the Advisory Council was also directed to

advise the Surgeon General with respect to the establishment of special advisory, technical, local or regional boards, committees or commissions. Under the pending bill the Advisory Council is authorized to establish such groups, whose membership may include members of the Council or other persons or both, to advise on general or special questions, professional and technical subjects, questions concerning administration, problems affecting regions or localities, and related matters.

SELECTION OF PHYSICIANS; ACCEPTANCE OF PATIENTS; PANELS

The Surgeon General will be required to publish and otherwise make known in each local area to individuals entitled to benefits the names of medical and dental practitioners and groups of practitioners who agree to furnish services as benefits and to make such lists of names readily available to individuals entitled to benefits. A new provision in the pending bill provides that such lists must include general or family practitioners and qualified specialists and consultants. With respect to qualified specialists and consultants the lists must indicate the class or classes of specialist or consultant services for which each has been qualified. Any physician, dentist or nurse legally qualified by a state to furnish any services included as personal health service benefits will be legally qualified to furnish such benefits, including any group of physicians, dentists or nurses or combinations thereof whose members are similarly qualified. A limitation contained in the first bill conditioning the participation by a physician on rules and regulations prescribed by the Surgeon General has been eliminated.

Likewise a beneficiary may select any practitioner appearing on a panel to treat him subject to the consent of the practitioner or the group of practitioners, as the case may be. This freedom of choice of practitioner is conditioned, however, on the right of the Surgeon General to prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish services, and such limits may be nationally uniform or may be adapted to take account of "relevant factors." A restriction in the old bill that the freedom of choice of physician must be exercised in accordance with such rules and regulations as the Surgeon General may prescribe has been eliminated. A new provision, however, has been added to the effect that every beneficiary and every group of beneficiaries will be permitted to make selection of a practitioner through a representative of his own choosing.

As in the bill introduced in the Seventy-Eighth Congress, the services of specialists, or consultants as

added by the pending bill, will ordinarily be available only on the advice of the general practitioner. This is modified in the new bill so that such services may be made available on the advice of a specialist or consultant attending the individual or "when requested by an individual entitled to specialist and consultant services as benefits and approved by a medical administrative officer appointed by the Surgeon General."

The Surgeon General will designate what shall constitute specialist or consultant services. He will likewise determine who are qualified to render such services, in accordance with general standards prescribed by him after consultation with the Advisory Council. In establishing standards and in designating specialists and consultants, the Surgeon General will be required to "utilize standards and certifications developed by competent professional agencies" and must "take into account the personnel resources and needs of regions and local areas."

PAYMENTS FOR THE SERVICES OF PRACTITIONERS

Payments to general medical and family practitioners or to general dental practitioners may be made (1) on the basis of fees for services rendered, according to a fee schedule, (2) on a per capita basis, the amount being according to the number of individuals entitled to benefits who are on the practitioner's list, (3) on a salary basis, full time or part time or (4) on a combination or modification of these bases, as the Surgeon General may approve. The method of payment will apparently be determined in each local area as the majority of the general medical and family practitioners or of the general dental practitioners, respectively, may elect. A new proviso authorizes the Surgeon General to make payments by another method from the one selected in a local area to those general medical and family practitioners or general dental practitioners who do not elect the method designated by the majority. Any of the methods of making payments indicated in the foregoing may be used, as the Surgeon General may approve, in making payment to groups of practitioners that contain designated specialists or consultants as well as general or family practitioners. The Surgeon General may negotiate agreements or cooperative working arrangements to utilize inclusive services of hospitals and their staffs or attending staffs and may enter into contracts for such inclusive services.

Payments to designated specialists and consultants may be made on the basis of salary (whole time or part time), "per session," fee for service, per capita or other basis or combination, as the Surgeon General and the specialists and consultants may agree.

Rates or amounts of payment for particular services or classes of services may be nationally uniform or may be

adapted to take account of relevant regional or local conditions and other factors. The bill contains a new provision that payments shall be adequate, "especially in terms of annual income or its equivalent and by reference to annual income customarily received among physicians, dentists and nurses, having regard for age, specialization and type of community." Payment will be commensurate with skill, experience and responsibility involved in furnishing service. In any local area where payment for services of a general or family practitioner is only on a per capita basis, the Surgeon General, the bill proposes, shall make per capita payments on a pro rata basis among the practitioners and groups of practitioners of the local area on the panel with respect to those individuals who after due notice have failed to select a general or family practitioner or who, having made one or more successive selections, have been refused by the practitioner or practitioners selected.

In each local area the provision of general medical or dental benefits will be a collective responsibility of all qualified general medical or family practitioners or of all qualified general dental practitioners, respectively, in the area who have undertaken to furnish such benefits.

* * * *

LIMITATIONS ON GENERAL MEDICAL, GENERAL DENTAL, HOME NURSING AND LABORATORY BENEFITS

The Surgeon General, after consultation with the Advisory Council and subject to the approval of the Administrator of the Federal Security Agency, may determine that every individual entitled to general medical, general dental or home nursing benefits may be required by the physician, dentist or nurse attending him to pay a fee with respect to the first service or with respect to each service in a period of sickness or course of treatment if he believes that such a limitation is necessary and desirable to prevent or reduce abuses of entitlement to the benefits. The maximum amount of such fee shall be fixed by the Surgeon General after consultation with the Advisory Council and with the approval of the Administrator of the Federal Security Agency. He may also limit the application of such fees to home calls, to office visits or to both.

* * * *

... the Surgeon General, after consultation with the Advisory Council and with the approval of the Federal Security Administrator, may limit for any calendar year or part thereof the cost of laboratory benefits. Such limitations may relate to a class of services, supplies or commodities, to maximum payments per beneficiary in a benefit year, to a specified fraction of the cost or to combinations thereof.

PROPOSED METHOD OF ADMINISTRATION

The bill provides that the Surgeon General shall perform the duties imposed on him under the supervision and direction of the Federal Security Administrator and after consultation with the Advisory Council *as to questions of general policy and administration*. He will be authorized to take all necessary steps to arrange for the availability of the benefits provided. He will be authorized, after consultation with the Advisory Council *as to questions of general policy and administration* and with the approval of the Administrator to negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any state or political subdivision, and with other appropriate public agencies. He may, too, make such agreements or arrangements with private persons or groups of persons to utilize their services and facilities and to pay fair reasonable and equitable compensation therefor. He may negotiate and periodically renegotiate agreements or cooperative working arrangements for the purchase or availability of supplies and commodities necessary for the benefits provided in the bill and to enter into contracts for such services, facilities, supplies and commodities.

Except with respect to state or local areas for which other arrangements have been made, the Surgeon General will be directed to appoint local area committees to aid in the administration of the part of the bill relating to compulsory health insurance. These committees will include representatives of persons entitled to receive services and benefits, the practitioners, the groups of practitioners, institutions and agencies furnishing services as benefits, and other persons informed on the need for, or provision of, personal health services. Such committees, the bill provides, must be consulted at frequent intervals and must be kept informed by the local area officers of the Public Health Service with respect to arrangements for the availability of benefits and policies to be followed.

The Surgeon General will be directed to give priority and preference to utilizing the facilities of state and local departments or agencies on the basis of mutual agreements with such departments or agencies. He may delegate to any officer or employee of the United States Public Health Service or of any federal, state or local cooperating department or agency such of his powers and duties, except the prescribing of rules and regulations, as he may consider necessary and proper. He may, after consultation with the Social Security Board, after consultation with the Advisory Council *as to questions of general policy and administration*, and with the approval

of the Federal Security Administrator, prescribe and publish such rules and regulations and require such records and reports, not inconsistent with other provisions of the bill, as may be necessary.

The Surgeon General will be required to make a full report to Congress, at the beginning of each regular session, of the administration of the functions devolved on him by the bill, and such reports must include "a record of consultation with the Advisory Council, recommendations of the Advisory Council, and comments thereon."

RELATION TO WORKMEN'S COMPENSATION BENEFITS

No individual will be entitled to any personal health service benefits with respect to any injury, disease or disability on account of which any medical, dental, home nursing, laboratory or hospitalization service is being received, or on application would be received, under a workmen's compensation plan for the United States or of any state.

BENEFITS FOR NONINSURED PERSONS

Benefits may be extended to noninsured persons on behalf of whom equitable payments are made or assured by public agencies of the United States, the several states, or any of them or of their political subdivisions. The bill specifically extends this provision to groups of persons for whom the Congress makes provision under the Social Security Act and other acts of Congress.

ADDITIONAL BENEFITS IN CONTEMPLATION

The Surgeon General and the Social Security Board will be jointly given the duty of studying and making recommendations as to the most effective method of providing dental, nursing and other benefits not already provided for and of reporting their recommendations as to legislation from time to time but not later than two years after the enactment of this bill. The studies and recommendations will relate to expected costs for the additional benefits and a desirable division of the costs between (1) financial resources of the social security system or other public fund and (2) payments to be required of beneficiaries receiving such benefits. Specifically, the Surgeon General and the Social Security Board are mandated to study and make recommendations as to needed services and facilities for the care of the "chronic sick" afflicted with physical ailments and for the care of individuals affected with mental or nervous diseases, recommendations as to legislation to be submitted from time to time but not later than three years after the enactment of this bill.

GRANTS-IN-AID FOR MEDICAL EDUCATION, RESEARCH
AND PREVENTION OF DISEASE AND DISABILITY

With the exceptions noted, the provisions in the pending bill authorizing grants for medical education, research and prevention of disease and disability are identical with those that were contained in the original Wagner-Murray-Dingell bill. Under these provisions the Surgeon General will be authorized to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education. Such grants will be made with respect to each project (1) for which application has been received from a nonprofit institution or agency, stating the nature of the project and giving the reasons for the need of financial assistance in carrying it out, and (2) for which the Surgeon General finds, with the advice of the Council and *after consultation with other federal departments and agencies concerned with research or professional education* that the project shows a promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, dental, nursing hospital, laboratory, disability, rehabilitation and related benefits, or to human knowledge with respect to the cause, prevention, mitigation or method of diagnosis or treatment of disease and disability.

Another new provision would make it mandatory that the Surgeon General and the Advisory Council give preference and priority, during the five year period beginning Jan. 1, 1946, to grants-in-aid with respect to projects to aid servicemen seeking postgraduate education as medical or dental practitioners or training for administration of personal health services, disability benefits, rehabilitation services and related services.

To finance this part of the program a certain percentage of amounts expended for benefits from the social security trust fund will be set aside. The amount to be set aside, the bill provides, will equal 1 per cent of the total amount expended for benefits from the trust fund, exclusive of unemployment insurance benefits, or 2 per cent of the amount expended for personal health service benefits after the latter benefits have been payable for not less than twelve months, whichever is the lesser, in the last preceding fiscal year.

EXISTING PREPAYMENT PLANS

Senator Wagner believes that the enactment of S. 1050 will not necessarily result in the displacement of existing prepayment medical service and hospitalization plans. In the statement that he made to the Senate when the bill was introduced, he said:

"There has been much misunderstanding about the part that voluntary hospitals, group service organizations, existing voluntary insurance or prepayment plans and similar agencies may play in the social insurance system. Let me emphasize that our bill makes a place for them, so that they can continue their good work. All qualified hospitals, all qualified medical groups or organizations, will be able to participate in the program as organizations that will furnish services to the insured persons who choose them, they will receive fair payments for the services they furnish as insurance benefits and they will have enlarged opportunities to be service agencies for particular groups or for their communities. This applies to service organizations created by trade unions, consumer groups, employers, nonprofit community groups, churches, fraternal associations, groups of doctors or individual doctors, medical societies or many other kinds of sponsors or combinations of sponsors. The bill not only provides for utilizing existing service organizations but it also encourages the creation of new ones.

"The Blue Cross hospital insurance plans will be able to continue to act as representatives of the participating hospitals and the community groups that own or manage the hospitals, and they will have large opportunities to be important public organizations that facilitate the administration of vital parts of the insurance system. The same will be true for many other community and public organizations.

"Medical service groups (private clinics, salaried staffs of hospitals, group-service plans such as the Kaiser or the Ross-Loos plan) furnishing service under the social insurance system would be as free as they are today to select their own staffs and their own method of paying physicians and others on their staffs, irrespective of the method of payment which prevailed among the individually practicing physicians or dentists of the local area."

The bill itself, however, does not specifically mention existing prepayment medical service and hospitalization plans. It does direct the Surgeon General, after consultation with the Advisory Council as to questions of general policy and administration, and with the approval of the Federal Security Administrator, to make agreements or arrangements with private agencies or institutions, or with private persons or groups of persons, to utilize their services and facilities. To what extent the importance and effectiveness of existing plans could be preserved under such agreements or arrangements is a matter about which many will entertain serious doubts.

—J. A. M. A., 1945, 128, 369.

News and Personals

The American Board of Ophthalmology announces that due to transportation difficulties the examination of the Board, originally scheduled for Chicago, October 1945, will be held January 18 to 22, 1946, in Chicago. Examinations will also be held in New York during May or June of 1946.

The School of Medicine, University of Pittsburgh, offers an Orientation Course in Clinical Allergy, under the sponsorship of the American Academy of Allergy, for five days, October 1 to 5, 1945, at the School on Bayard Street, Pittsburgh. Registration fee for veterans, service men and residents is \$10.00; open registration, \$40.00. Inquiries should be addressed to Dr. William S. McEllroy, Dean of the School of Medicine, University of Pittsburgh, Pittsburgh 13, Pa.

The Honorable Guy Mason, Commissioner for the District of Columbia, has announced the formation of a new Veterans' Advisory Committee to assist veterans seeking to study medicine, pharmacy, dentistry, medical technology, nursing and allied sciences. Dr. Paul F. Dickens, State Chairman, Procurement and Assignment Service for Physicians, War Manpower Commission, will serve as Chairman of the Committee. The Committee will function as an adjunct to the District Government's present advisers from Federal agencies for handling veterans' affairs. Other members of the Committee are as follows: Dr. Walter A. Bloedorn, Dean of George Washington University School of Medicine; Father David V. McCauley, Dean of Georgetown University School of Medicine; Dr. John W. Lawlah, Dean of Howard University School of Medicine; Dr. John P. Burke, Dean of Georgetown University School of Dentistry; Dr. Roger M. Choisser, head of George Washington University School of Medical Technicians; Sister Marie Gerarda, Superintendent of Nurses, Georgetown University Hospital; Mrs. Helen Shoemaker, Superintendent of Nurses, Sibley Memorial Hospital; Lloyd W. Hazleton, Execu-

tive Officer of George Washington University School of Pharmacy, and Theodore Wiprud, Secretary of the Medical Society of the District of Columbia as Executive Secretary of the Committee.

Any veteran seeking information on the various schools can call the War Manpower Commission Office of Procurement and Assignment Service for Physicians, 1718 M Street, N.W., Executive 0970, which in turn will refer the applicant to the proper committee member.

The Army Medical Department celebrated its 170th anniversary, July 27. Deputy Surgeon General George F. Lull, in a radio address from Valley Forge, the birthplace of the Medical Department, related how the Continental Congress acted upon General George Washington's request in 1775 that a Medical Department be organized because "the lives and health of both officers and men so much depend on a due regulation of this department." General Lull called attention to the fact that today's Medical Department, more than one-half million strong, is gearing itself to new high standards in the care of America's sick and wounded at home and abroad. "We are justifiably proud of our World War II record of returning nearly ninety-seven of every hundred of our disabled soldiers to duty," he said.

Walter Reed Hospital and the Army Medical Center held open house for 5,000 persons who were given an opportunity to inspect the buildings and their services during the birthday celebration. Present to give one of the regular medical lectures presented to patients by leading doctors and scientists was Sir Alexander Fleming, who described the discovery of penicillin.

During the month of August a number of members in service, most of whom had been on duty overseas, visited the Society's offices. Some of them expected to be discharged but others were en route to new assignments. They were: **Lt. Colonel James N. Greear**, who left early in 1945 for overseas while

serving as President of the Society; **Captain Raymond T. Holden**, who has been stationed in England for nearly two years; **Lt. Colonel Ivy A. Pelzman**, who had served overseas in the Southwest Pacific area; **Lt. Colonel G. Victor Simpson**, who was making a brief visit in Washington before returning to Plattsburg Barracks, Plattsburg, New York; **Lt. Comdr. Paul O'Donnell**, who had served recently on the U. S. S. *Lowndes*; **Majors J. Phelps Hand, Darrell C. Crain and Howard Katzman**, who were back in the states after more than two years' service overseas with the Army Medical Corps; and **Major William J. Tobin**, who expects to go abroad shortly. Major Tobin has been Chief of the Orthopedic Section of the Cushing General Hospital, Framingham, Mass.

Dr. William Arthur Morgan, well known otolaryngologist, will have named in his honor the hospital now under construction in Ciudad Trujillo, Dominican Republic. This unusual tribute is in recognition of the humanitarian services rendered by Dr. Morgan on a visit to that country early this year, in the course of which he performed approximately 700 operations, chiefly among indigents.

The hospital, of modern architectural design, will have a capacity of 180 beds. It will overlook the first permanent city of the New World, founded by Barolome Colón, brother of Christopher Columbus. Certain rooms in the hospital will be reserved for Dr. Morgan, who plans to return to the West Indies for several months annually and will be present for the dedication ceremony at the end of this year.

Dr. Morgan is a native of Raleigh, N. C. He graduated from the Medical College of Virginia in 1917. Following his graduation he served as a lieutenant in the United States Navy during World War I. Later he became a major in the Army Medical Reserve Corps. Dr. Morgan is Chief of Otolaryngology at Doctors and Sibley Hospitals.

Dr. C. Willard Camalier, Chairman of the War Service and Postwar Planning Committee of the American Dental Association, met with his Committee at the Mayflower Hotel, August 13, to consider problems relating to the eventual return of some 22,000 dentists to private practice. The Committee made plans to coöperate with dental schools throughout the Nation in providing postgraduate

and refresher courses for both service and civilian practitioners. Courses will be presented locally in dental schools at Georgetown, Howard and Maryland Universities.

Approximately 30 dentists from the Midwest and Atlantic Seaboard states attended the Committee meeting. Among them was **Dr. Sterling V. Mead**, the Association's President-elect.

The medical fraternities of Georgetown University School of Medicine are sponsoring a dance for the purpose of raising funds for the new **Georgetown Hospital**. The dance will be held at the Shoreham Hotel, Friday night, September 28. Members of Lambda Phi Mu, Phi Chi and Phi Delta Epsilon are soliciting the support of members, friends and alumni to make this interfraternity dance a social and financial success. Representatives of the fraternities will distribute tickets at the various hospitals and tickets may be purchased at the dance.

Dr. Beatrice Bishop Berle, now living in Rio de Janeiro, is on the visiting staff of the Santa Casa de Misericordia, one of the city's oldest charity hospitals.

Dr. Samuel A. Silk has been promoted to First Assistant Physician of St. Elizabeths Hospital and **Dr. Addison M. Duval**, to Clinical Director.

Dr. Guy W. Leadbetter, Chief of the Orthopedic Service of Emergency Hospital, spoke at the capping ceremonies for 33 cadet nurses at the Nurses Home of Emergency Hospital, July 27.

Dr. Benjamin I. Weininger will replace Dr. Michael J. Miller as head of the new D. C. Alcoholic Clinic.

Dr. Hugh Hampton Young, internationally known urologist, died August 24, at the age of 74 years, in the Brady Clinic which he founded. Dr. Young was well known as a patron of the arts, sportsman, political counselor, traveler, inventor and civic leader. The *Washington Post* in an editorial characterized him as "one of the surgical titans of his time, as well as a fabulous personality. Life in Baltimore seems almost drab to contemplate without Hugh Young."

Dr. Young first compounded Mercurochrome; he invented the "boomerang" needle for sewing deep incisions, a special type of operating table, and a score of scientific instruments. What medical historians have called one of the major contributions to surgery in the twentieth century was his operation for the removal of the prostate gland, which he first performed in 1903.

Dr. Young was born September 18, 1870, in San Antonio, Texas. He received his degree as Doctor of Medicine from the University of Virginia in 1894. In 1897 he became head of the Department of Urological Surgery at Johns Hopkins University; until his retirement in 1942, he was head of the Brady Clinic, which was endowed by his old friend and patient, "Diamond Jim" Brady.

He was Editor of the *Journal of Urology* and had written half a dozen volumes and more than 200 articles on medical subjects. He had held many important professional offices, among them the presidency of the American Association of Genito-Urinary Surgeons, American Urological Association, Medical and Chirurgical Faculty of Maryland and the International Association of Urology. He was the United States' first medical representative to France in World War I. He attended President Wilson in his last illness.

MEETINGS

Wednesday, October 10

"Acute Poliomyelitis," CHARLES ARMSTRONG, M.D., United States Public Health Service.

Wednesday, October 17

DAVIDSON LECTURE

Speaker and subject to be announced.

Wednesday, October 24

"Penicillin and Antibiotics," WALLACE E. HERRELL, M.D., F.A.C.P., Assistant Professor of Medicine, Mayo Foundation.

Sunday, October 28

TROPICAL DISEASE SEMINAR

COLONEL J. E. ASH AND ASSOCIATES, Army Medical Museum.

Wednesday, October 31

"Diseases of the Breast," COMDR. CHARLES F. GESCHICKTER, M.C., U.S.N.R., United States Naval Medical Center.

CORRESPONDENCE

WASHINGTON, D. C., August 2, 1945

MR. THEODORE WIPRUD, SECRETARY
D. C. MEDICAL SOCIETY
1718 M Street, N. W.
WASHINGTON, D. C.

DEAR TED:

The enclosed copy of a letter addressed to Dr. Ruhland and a report of the Federal Grand Jury at Muskogee, Oklahoma are self-explanatory.

I acknowledged their receipt to Mr. Martin and informed him I was forwarding copies on to you. I expressed the thought in my letter to him that you might publish the report in *MEDICAL ANNALS*.

Your attention is directed to the last paragraph of his letter relative to being placed on your mailing list.

Very sincerely,
PAUL FOLEY
*Assistant Secretary,
Commission on Licensure,
Healing Arts Practice Act,
District of Columbia*

BALTIMORE, MD., July 27, 1945

DR. GEORGE C. RUHLAND
6150 EAST MUNICIPAL BUILDING
WASHINGTON, D. C.

SIR:

In re: Telephone narcotic orders.

I have just received a communication from Commissioner of Narcotics H. J. Anslinger, dated July 23, 1945, to which was attached a copy of a report of the Federal Grand Jury sitting at Muskogee, Oklahoma, dated June 26, 1945, concerning the taking of narcotic prescriptions over the telephone by druggists.

I am attaching hereto a copy of the Grand Jury report, and it is suggested that it be reprinted in any monthly journal or publication you may have for distribution to the medical profession in the District of Columbia.

In the event you have any such publication, this office would appreciate being placed on the mailing list.

Respectfully,
B. M. MARTIN
*District Supervisor,
Bureau of Narcotics,
Treasury Department*

REPORT OF THE FEDERAL GRAND JURY AT
MUSKOGEE, OKLAHOMA, DATED JUNE 26, 1945

"We also beg to report that we have made a partial investigation of a report concerning laxity in the dispensing of narcotics by some of the medical profession and some of the druggists. The facts developed disclosed a rather shocking disregard of the law. In some instances it appears now that some druggists fill telephone prescriptions for narcotics and later take the prescriptions to the doctor for his signature. It also appears now that an unnecessarily large quantity of narcotics is being dispensed by some druggists and physicians to persons who are well known addicts. The investigation thus far reveals an astounding condition in this respect. We do not wish to place ourselves in a position or attempt to determine when or under what manner, or in what quantities a person may need narcotics for the alleviation of pain and suffering, but we feel that we are in position to say that the conditions above referred to are intolerable and wholly unwarranted, and if continued can only result in an indictment wherever warranted. It has been stated in defense of this condition that the doctors are overworked and prescriptions by telephone are time-savers. We are conscious of the overworked condition of most of our physicians, but we disagree with the contention that such practice is warranted in order to save time. It is a matter of obeying or violating the law.

"We are making this report at this time in the hope that these abuses, as well as any others not mentioned herein, may be speedily corrected. We propose to pursue this investigation further when next called and will then take such action as the facts and circumstances warrant at that time."

WASHINGTON, D. C., July 14, 1945

MR. THEODORE WIPRUD, SECRETARY

D. C. MEDICAL SOCIETY

1718 M STREET, N.W.

WASHINGTON, D. C.

DEAR MR. WIPRUD:

On behalf of the District of Columbia Pharmaceutical Association, I wish to thank you and through you the District of Columbia Medical Society for the kind invitation extended to the pharmacists of Washington to be present on the occasion of Sir Alexander Fleming's recent talk on Penicillin.

I am sure that the many pharmacists present on the occasion were benefited considerably by Dr. Fleming's talk on Penicillin, since it was most interesting and informative.

In the writer's humble opinion the dissemination of knowledge and information on such timely subjects, through the medium of joint meetings of the several groups interested in Public Health, is definitely advantageous, not only to the several professions represented but to the public as a whole.

Very sincerely yours,

JOHN E. DONALDSON

President, District of Columbia

Pharmaceutical Association

BOOK REVIEW

The Doctor's Job. CARL BINGER, M.D. Price, \$3.00. Pp. 235. New York: Norton, 1945.

This interesting book emphasizes particularly changes in medicine in the author-physician's own lifetime. He traces the medical man's development from the all-knowing general practitioner through the age of overemphasis on specialists into the modern concept of the office of the internist as a clearing house through which patients should pass on their way to specialists, if necessary. The most important job of the present-day physician, according to Dr. Binger, is the prevention and early detection of physical and mental illness and the maintenance of an excellent personal relationship between doctor and patient. The most important things a doctor can give are his time, his care, and his interest. The physician is becoming more of a teacher than ever before, or, in Dr. Binger's words, "a repairman who instructs others in maintenance and upkeep."

Four whole chapters and much else in the book are devoted to the enormous influence of psychoanalysis on both psychiatry and medicine. He feels that there is great need of more and better teaching in this rapidly expanding field in our medical schools. He wants physicians and the public to better understand that subtle interplay of mind and body currently referred to as psychosomatic medicine.

Since advances in medical science have prolonged the lives of so many individuals, the problem of chronic illness common to older people is a big part of the doctor's job today. The socioeconomic problems confronted are enormous and numerous. He believes that medical men should be allowed to settle the medical side of the question, and that statisticians, social workers, and others qualified should be allowed to solve the social side. He favors supporting local experiments, such as Mayor LaGuardia's New York scheme. He does not believe that the solution lies in anything as widesweeping as the Wagner-Murray-Dingell bill, which we are not prepared to handle.

The book is well thought through, the product of a lifetime of experience, study, and clear thinking. Its interesting anecdotes, fluent style, and excellent construction make it a pleasure to read. This seems to be an example of a prize-winning book that really deserved to win the prize.

M. B. Y.

REPRINTS RECEIVED

The following reprints have recently been received, for which due acknowledgment is made:

"Community Organization for the Control of Rheumatic Fever." Donald B. Armstrong and George M. Wheatley. *New York State Journal of Medicine*, January 15, 1945.

"Some Recent Advances in the Control of Infectious Disease." Francis G. Blake. *Rhode Island Medical Journal*, June 1945.

"Acute Obstruction of the Colon." George V. Brindley. *Surgery, Gynecology and Obstetrics*, May 1944.

"Acute Obstructions of the Colon." George V. Brindley. *Texas State Journal of Medicine*, March 1945.

"Sacral and Presacral Tumors." George V. Brindley. *Annals of Surgery*, May 1945.

"The Economic Basis of Health." Andrew T. Court. *Proceedings of Ninth Annual Meeting of Industrial Hygiene Foundation of America*, November 15-16, 1944.

"The Control of Rat Fleas (*Xenopsylla cheopis*) by DDT." David E. Davis. *Public Health Reports*, May 4, 1945.

"Digests of Papers Presented at the National Conference on Postwar Venereal Disease Control, November 9-11, 1944." *Journal of Social Hygiene, Supplement*, January 1945.

"Tests of Epidemic Typhus Vaccines." Richard Donovick and Ralph W. G. Wyckoff. *Public Health Reports*, May 18, 1945.

"An Outward Opening Combination Storm and Screen Door." R. E. Dorer. *Public Health Reports*, February 2, 1945.

"Psittacosis; Occurrence in the United States and Report of 97 Per cent Mortality in a Shipment of Psittacine Birds While Under Quarantine." G. L. Dunnahoo and Brock C. Hampton. *Public Health Reports*, March 30, 1945.

"Naturopathic Legislation and Education." John E. Farrell. *Rhode Island Medical Journal*, April 1945.

"Occurrence of Pulmonary Tuberculosis in Supposedly Screened Selectees." Col. Arden Freer. *Diseases of the Chest*, May-June 1944.

"Post-War Teaching of Tuberculosis." Charles M. Hendricks. *Diseases of the Chest*, May-June 1944.

"What We Know About Longevity." Theodore G. Klumpp. *The American Mercury*, April 1945.

"A Comparison of the Effect of Penicillin and Immune Serum in the Treatment of Experimental Leptospirosis in

Young White Mice and in Hamsters." C. L. Larson and J. J. Griffiths. *Public Health Reports*, March 23, 1945.

"Hypertensive Encephalopathy; a Clinical Consideration." Arnold McNitt. *Southern Medical Journal*, December 1944.

"The New Wagner-Murray-Dingell Bill: A Factual Summary; An Interpretation; Some Conclusions." *Medical Economics*, July 1945.

"Bill Establishing a National Neuropsychiatric Institute Presented to Congress." *Mental Hygiene*, April 1945.

"Medicine and the Neuroses: Report of the Hershey Conference on Psychiatric Rehabilitation." New York: National Committee for Mental Hygiene, Inc., 1945.

"President's New Year Message." Jay Arthur Myers. *Diseases of the Chest*, January-February 1945.

"Toxicity and Potential Danger of Aerosols and Residues from Such Aerosols Containing Three Per cent DDT." P. A. Neal, W. F. von Oettingen, R. C. Dunn and N. E. Sharpless. *Public Health Reports*, Supplement No. 183, 1945.

"Syllabus of Audiometric Procedures in the Administration of a Program for the Conservation of Hearing of School Children," edited by Horace Newhart and Scott N. Reger. *Transactions of the American Academy of Ophthalmology and Otolaryngology, Supplement*, April 1945.

"Medical Management of Uncomplicated Peptic Ulcer." W. D. Paul and C. Rhomberg. *Journal of the Iowa State Medical Society*, May 1945.

"Further Studies on the Pharmacologic Action of 2,2 Bis (p-Chlorophenyl) 1,1,1 Trichlorethane (DDT)." M. I. Smith and E. F. Stohlman. *Public Health Reports*, March 16, 1945.

"The Need for Planning the Economic Rehabilitation of the Tuberculous." H. I. Spector. *Diseases of the Chest*, March-April 1944.

"Influence of Added Rennin upon Curd-Forming Properties and Peptic Digestion of Milk." Bernhard Spur and Irving J. Wolman. *Journal of Dairy Science*, February 1945.

"The Titration of *Clostridium Perfringens* (Welchii) Antitoxin by Its Antihemolytic Activity." Sarah E. Stewart. *Public Health Reports*, March 30, 1945.

"Preliminary Report on the Identification of 2,2 Bis (p-Chlorophenyl)-1,1,1 Trichlorethane (DDT) in the Excreta of Poisoned Rabbits." E. F. Stohlman. *Public Health Reports*, March 30, 1945.

"The Tropical Disease, Filariasis." Haight Thompson. *The American Mercury*, April 1945.

"Tubovalvular Gastrostomy: History and Technique." Max Thorek. *Journal of the Michigan State Medical Society*, February 1945.

"Studies of Typhus Fever." N. H. Topping, and others. *National Institute of Health Bulletin No. 183*. Washington: U. S. Government Printing Office, 1945.

"Carbon Monoxide: Its Hazards and the Mechanism of Its Action." W. F. von Oettingen. *Public Health Bulletin No. 290*. Washington: U. S. Government Printing Office, 1944.

"Prostigmine—A New Wonder Drug." Leona Alberts Wassersug. *The American Mercury*, May 1945.

JESSE SHOUP, B.S., M.D.
(1865-1945)

Dr. Jesse Shoup, a Life Member of the Medical Society of the District of Columbia, died July 21 at Doctors Hospital. He resided at 200 Maryland Avenue, N.E.

Dr. Shoup was born in 1865 near Dayton in Green County, Ohio. He received the degree of Bachelor of Science from Ohio Normal University in 1888 and graduated from the Jefferson Medical College of Philadelphia in 1891. The same year he began practicing medicine in Dayton, Ohio. A few years later, 1894, he secured his license to practice in the District of Columbia and continued to serve the District as a general practitioner for half a century. He had held staff appointments at Providence, Sibley and Garfield Hospitals.

Dr. Shoup had been affiliated with both the Medical Association of the District of Columbia and the Medical Society of the District of Columbia, becoming a member of the former in 1896 and of the latter in 1902. He had been a Life Member since 1937.

He was a Fellow of the American Medical Association, an Associate of the American College of Physicians, a member of the Washington Heart Association, and a charter member of the Washington Medical and Surgical Society.

His wife, Mrs. Anna Shoup, survives him, together with a brother, Arthur A. Shoup, and a sister, Miss Olive Shoup, both of Dayton, Ohio.

EDWARD LLOYD MORRISON, M.D.
(1879-1945)

Dr. Edward L. Morrison, well known ophthalmologist, died suddenly August 14 at Doctors Hospital.

Dr. Morrison took a prominent role in the development of the Medical Center. He was Vice President of the four constituent units of the Center, viz., Doctors Hospital, Columbia Medical Building Corporation, Washington Medical Building Corporation and the Columbia Operating Corporation.

Born in Phillipsburg, Pa., September 23, 1879, he received his early education at Jersey Shore, Pa. He graduated from the Jefferson Medical College of Philadelphia in 1905. The following year he served as resident physician at Lock Haven General Hos-

pital, Lock Haven, Pa., and from 1907 to 1913 as Assistant Physician at the State Hospital, Harrisburg, Pa.

Deciding to specialize in ophthalmology, Dr. Morrison enrolled at the Philadelphia Polyclinic and College for Graduates in Medicine. In June, 1913 he entered the Episcopal Eye, Ear and Throat Hospital in Washington as senior resident physician in ophthalmology. After a six months' residency he continued as a staff member in association with the late Dr. William Holland Wilmer. Since 1926 he had been engaged in private practice in Washington, confining his practice to his specialty. His office was located at 1835 Eye Street, N.W.

Dr. Morrison was a Fellow of the American Medical Association, an Active Member of the Medical Society of the District of Columbia since 1915, a diplomate of the American Board of Ophthalmology, and a member of the James C. Wilson Medical Society of Jefferson Medical College. He was a thirty-second degree Mason.

He is survived by his wife, Mrs. Jeannette Turner Morrison, who resides at their home in Rockville, Md., and two brothers, Louis M. Morrison of Albany, New York, and Fred Morrison of Clewiston, Fla.

Penicillin Therapy of Gonorrhea—Chinn and Gillick
(Continued from page 408)

ACKNOWLEDGMENT

This work was carried out by the coöperative efforts of the staff of the Bureau of Venereal Diseases of the D. C. Health Department. We wish to acknowledge especially the interest and encouragement of Dr. George C. Ruhland, Health Officer, and the active participation in this study of Dr. Iva G. Murphy, Dr. Sidney Olansky, Dr. B. J. Newhouse, Dr. R. G. James and Dr. A. B. Greaves.

Bacteriologic analysis of cultures was performed by Dr. J. B. Noble of the D. C. Health Department, and blood levels were obtained through the courtesy of Dr. L. E. Putnam of the Food and Drug Administration.

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1945-1946

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HOST VARIATION IN THE MANIFESTATION OF DISEASE: WITH PARTICULAR REFERENCE TO HOMOLOGOUS SERUM JAUNDICE IN THE ARMY OF THE UNITED STATES*

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N MARCH of 1942 a sudden rise in incidence of jaundice in the personnel of the Army of the United States was observed, due to the presence of an icterogenic agent in certain lots of yellow fever vaccine which these men and women had received. After a prolonged incubation period of about 90 days mean duration this icterogenic agent, believed to be a virus, is capable of inducing a disease similar to, if indeed not identical with, infectious hepatitis. Prompt and energetic steps were taken by the Preventive Medicine Service of the Office of the Surgeon General to ascertain the cause of the outbreak and execute control measures.

For yellow fever vaccine to be effective it must rehydrate from the desiccated, frozen

form in which it is prepared, as a living virus capable of multiplication within the tissues of the recipient. The vaccine used in 1941 and the first 3½ months of 1942 contained a small amount of presumably normal human serum. The addition of serum to the vaccine prior to its desiccation was necessary in the earlier days of vaccine manufacture to ensure "protection" of the virus used. Serum-containing yellow fever vaccine was discontinued April 15, 1942, by which time it was possible to produce a satisfactory product containing no human serum ("AB" or aqueous-base vaccine).

Because of the long incubation period involved, the epidemic did not begin to wane until some weeks after April 15, 1942. The peak for weekly admissions for jaundice was not reached until the 7-day period ending June 20. Thereafter the cases rapidly fell off in number and by the end of the fourth week in October had reached a "low" quite comparable to the

* Acknowledgment is made to the Preventive Medicine Service, Army of the United States, Brigadier General J. S. Simmons, Chief, for appointment as Consultant in Infectious Diseases in the Office of the Surgeon General, which made possible this study.

incidence in January and February before the outbreak began to manifest itself.* Jaundice is usually present in small amounts in armies, due chiefly to chemical injury to the liver through accident, occupation or medication and to infectious disease, specifically to leptospirosis and infectious hepatitis, incidentally as a symptom in a number of other conditions. The monthly rate for December, 1941 for this "normally occurring" jaundice was only 0.10 cases per 1,000 men. For December, 1942 it was 0.09 cases per 1,000 men with actually 53 fewer cases in 1942 than would have occurred had the 1941 rate obtained. Yet between these two dates, within less than 1 year, 51,337 cases of homologous serum jaundice were reported, with as many as 4,334 new cases noted in the peak 7-day period. These cases occurred over wide areas of the United States and among our troops stationed abroad.

Walker¹ presents data showing that the peak for a naturally occurring epidemic of infectious hepatitis in 1943 in North Africa came in November, with the October cases almost equally numerous. In this African outbreak cases in June were minimal. The strength of the Army at the end of 1942 was 3 times the strength a year earlier. New and susceptible personnel were constantly being inducted. These facts clearly indicate that the vaccine-induced disease was controlled by the measures instituted and that, as it occurred, it was not communicable. Many of the epidemiologic, clinical and pathologic aspects of the outbreak have already been presented in papers by Sawyer

et al,² Bayne-Jones and Walker,³ Turner et al⁴ and Lucke,^{5, 6} and Walker's paper mentioned above carries numerous graphic representations of epidemiologic data regarding the epidemic.

The serum-base yellow fever vaccine furnished the Army derived from 117 different lots. The total number of doses given is recorded as 2,954,000. Nine of the 117 lots appear to have been more icterogenic than the other 108, but there is some evidence that all lots possessed at least some degree of icterogenicity.⁷ Among the 9 lots chiefly implicated were 2, No. 307 and No. 329, which furnished fewer than 6,000 doses of vaccine between them. From the other 7 lots, Nos. 331, 334, 335, 338, 367, 368 and 369, almost half a million doses of vaccine were administered (427,160).

Our interest in the situation derives from the fact that there is to be seen in this outbreak of jaundice in 1942 an extraordinary demonstration of the manner in which the human host responds to a controlled infection. It is rare that herd outbreaks can be observed in man under such uniform conditions as existed in this instance in which constant and standard doses of an etiologic agent were placed in the tissues of large numbers of young adults, predominately male, living under similar conditions and in like good health. There are epidemics of disease in which the time of infection is known, as, for instance, food poisoning and infection, typhoid fever from food served at a single meal, infections arising from a single contamination of milk, laboratory infections and the like, but in none of these has there been any control of the quantitative aspects of dosage of the etiologic agent nor such large numbers of individuals involved.

The method of study was the careful examination of various epidemiologic reports from areas where much "jaundice" had occurred, and of more than 13,000 patient questionnaires on file in the office of the Preventive Medicine Service. Periods of incubation were calculated and recorded with reference to the original date

* Cases of jaundice in the Army in 1942:

January...	89	July.....	10,814
February...	78	August....	4,395
March....	2,053	September..	1,433
April.....	5,641	October....	1,006
May.....	9,404	November..	533
June.....	15,429	December..	462

Reports are made by weeks. January, May, August and October have 5 weeks, each of the other months 4 weeks. Army strength in December was 2.91 greater than in January.

of inoculation, place, vaccine lot number, army affiliation and so on. The resulting data represent material obtained from a study of half of the available questionnaires on which the full data needed for all details of the study are to be found. By selecting given lot numbers and certain camps after preliminary inspection of all of the material, it is believed that the 50 per cent sample so obtained is large enough to warrant comment.

It is generally recognized that when any large number of individuals is exposed to the risk of infection not all will respond with obvious disease. In the data for the 1942 homologous serum outbreak in the Army the number of doses of vaccine presumably given is known and the number of recognized cases is on record. It was early recognized, however, that all vaccine lots were not equally virulent, and, since exact data do not exist for all recorded cases, the actual attack rate has to be approximated. Based upon the 26,771 questionnaire cases in which the vaccine lot number is known, Sawyer and associates² give the case rate per 1,000 doses as follows: 13.64 for lot No. 307; 16.97 for No. 329; 27.22 for No. 331; 34.13 for No. 334; 56.55 for No. 335; 31.52 for No. 338; 60.58 for No. 367; 67.59 for No. 368; and 95.80 for vaccine lot No. 369. The number of known cases caused by lot No. 369 is 5,288. The total number of cases from all lots of vaccines as reported in the weekly summaries is, as noted, 51,377. A simple extension by direct proportion of the case incidence per 1,000 inoculated personnel to cover the total number of recorded cases produces an incidence rate of 183.9 for lot No. 369. This indicates that even with the most "virulent" exposure to risk of disease provided in this "experiment," 4 out of each 5 individuals escaped.*

* The problem of calculating the exact case incidence is not so simple. To avoid confusion the reader is asked to remember that weekly a summary statement is forwarded from each unit of all illnesses. As far as homologous serum jaundice is concerned the number of such

There are, however, a number of instances in which the exact number immunized with a given lot number is known. At Moffet Field 3,554 men were immunized with lots No. 331, 335, 338 and 380. There were 175 cases of jaundice among these men, which is a rate of 49.24 per 1,000 men. Unit R/2093 had 501 cases among 2,749 men, a rate of 182 per 1,000. At West Point vaccine lot No. 368 was given to 1,580 officers and personnel between February 18 and March 15, 1942. Dr. K. F. Maxcy made a careful study of the outbreak of jaundice which followed and found 209 cases, a case incidence of 132.3 per 1,000 individuals. Other observations could be included, but all indicate that of the total number injected with a standard dose of icterogenic agent, 80 per cent or more present no recognizable sign or symptom. A certain number of those who escape may possess immunity in the usual classical sense, but it seems unlikely that homologous serum jaundice or its "anlage" is a condition to which 4 out of 5 have acquired an immunity as we commonly understand that term.

Homologous serum jaundice is a disease with a low case fatality, yet it presents a range of manifestations ranging from the mildest recognizable form to cases terminating fatally, and many of the recoveries require long conva-

cases reported totaled 51,377. Medical officers were requested to fill out and forward questionnaires for each case of jaundice as far as possible. More than 30,000 such questionnaires were submitted, of which number 26,771 were sufficiently detailed for use in our survey. (See Sawyer² for reproductions of the questionnaires used.)

The following are the data: Vaccine lot No. 331, number doses 64,300 with 1,750 cases, rate 27.22. Vaccine lot No. 334, number doses 12,540 with 428 cases, rate 34.13. Vaccine lot No. 335, number doses 68,280 with 3,851 cases, rate 56.55. Vaccine lot No. 338, number doses 70,900 with 2,235 cases, rate 31.52. Vaccine lot No. 367, number doses 76,640 with 4,643 cases, rate 60.58. Vaccine lot No. 368, number doses 79,300 with 5,360 cases, rate 67.59. Vaccine lot No. 369, number doses 55,200 with 5,288 cases, rate 95.80. Total of 117 lots, number doses 2,954,600 with 26,771 cases.

lescence. Turner and associates⁴ studied 4,083 patients at Camp Polk, among whom were 14 deaths. Lucke's study on the pathology of fatal epidemic hepatitis is based upon 125 fatal cases which occurred in civilian and military personnel of the Army. Practically all of Turner's patients had received their yellow fever immunization from vaccine lot No. 369. This is the most virulent of the different vaccine lots in the Army experience, with a "calculated" per 1,000 incidence of 183.9. If such a case incidence be assumed, the number of men originally inoculated with icterogenic vaccine at Camp Polk yielding the 4,083 cases and 14 deaths would be 22,000. Approximately 18,000 men responded with no sign to a stimulus which sickened 4,083 others, among whom 14 died. Each one of the entire lot may be thought of as of approximately equal physical vigor, as in good health, living under identical conditions of housing, exercise and nutrition, as of about the same age, and as having received the same dosage of infective agent.

In study of the "jaundice questionnaires" several series were obtained in which the individuals not only received the same vaccine lot number at a given camp but received it on the same day. Three such series will be discussed from the point of view of variation in incubation period. At Camp Polk on February 27, 1942 more than 5,000 soldiers were inoculated with vaccine lot No. 369 and remained at this camp for the next several months. Among them 1,004 cases of jaundice appeared. At Fort Custer on February 21, 1942 another group of men were immunized with vaccine lot No. 368. Some remained at Fort Custer and some were sent to Iceland. Data have been assembled on 377 who suffered homologous serum jaundice at Fort Custer and on 516 who became ill in Iceland. These data are presented in table 1.

In the Camp Polk experience the first reported case developed ("onset of symptoms") on the fifteenth day following immunization. It might

TABLE 1
The Period of Incubation for the Development of Postvaccinal Jaundice in the Three Series of Men Under Discussion

VACCINE LOT No.....	368	368	369
Inoculated	Fort Custer, Feb. 21, 1942	Fort Custer, Feb. 21, 1942	Camp Polk, Feb. 27, 1942
Jaundiced	Fort Custer	Iceland	Camp Polk
Total number	377	516	1004
days			
15			1
53	1	1	
61			1
62			7
63	1	1	2 11
64			2
65			4
66			2
67			1
68		1	2
69		6	4
70	1 1	7	2 17
71			6
72		4	4
73		3	8
74	3	2	14
75	1	6	7
76	3	10	28
77	3 10	5 30	12 79
78	2	1	11
79		5	19
80	1	11	15
81	3	10	34
82	9	11	13
83	8	9	24
84	7 30	10 57	43 159
85	9	5	18
86	4	18	40
87	2	10	15
88	8	12	18
89	4	2	18
90	11	16	20
91	5 43	15 78	9 138
92	10	6	3
93	14	38	52
94	12	5	28
95	6	36	19
96	7	21	15
97	9	18	24
98	3 61	13 137	29 170

TABLE 1—(Continued)

VACCINE LOT No. . . .	368	368	369
Inoculated	Fort Custer, Feb. 21, 1942	Fort Custer, Feb. 21, 1942	Camp Polk, Feb. 27, 1942
Jaundiced	Fort Custer	Iceland	Camp Polk
Total number	377	516	1004
days			
99	3	12	18
100	15	28	31
101	8	14	12
102	4	14	22
103	5	11	22
104	12	13	19
105	6 53	6 98	13 137
106	12	15	16
107	11	14	42
108	5	7	30
109	9	9	15
110	7	4	11
111	7	10	4
112	13 64	6 65	16 134
113	3	5	6
114	14	8	15
115	8	8	5
116	8	4	11
117	3	1	9
118	4		3
119	6 46	3 29	10 59
120	4	1	6
121	4	1	12
122	3	3	11
123	2		9
124	4		7
125	4		3
126	7 28	1 6	4 52
127		2	5
128	3	1	8
129	1	2	10
130	8		3
131	3	1	1
132	4	1	4
133	1 20	7	2 33
134	1		2
135	2		2
136	3	1	2
137	1		5
138			2
139	1		
140	1 9	1	13

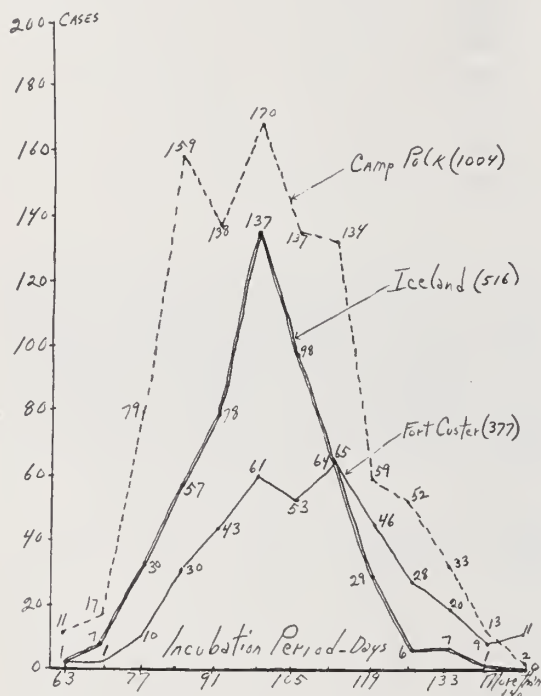
TABLE 1—(Concluded)

VACCINE LOT No. . . .	368	368	369
Inoculated	Fort Custer, Feb. 21, 1942	Fort Custer, Feb. 21, 1942	Camp Polk, Feb. 27, 1942
Jaundiced	Fort Custer	Iceland	Camp Polk
Total number	377	516	1004
days			
141	1		
142	2		
143	1		1
144	2		
145	1		
146	1		
147	1		1
149	1		
154	1 11		2

have been jaundice due to injury of the liver from sources other than the icterogenic agent present in the yellow fever vaccine. If it were true homologous serum jaundice it would be a fine example of the fact that in a complex biologic situation, such as the evolution of an infectious process, the "normal" may be an exceedingly variable entity. In the Eaton Rapids, Michigan typhoid outbreak described by Ramsey and associates,⁸ the first of 35 cases had an incubation period of 2 days, and the last case did not present symptoms till the forty-first day. Typhoid fever also resulted in Cleveland, Ohio from carrier-contaminated food eaten at a single meal and here, as reported by Perkins,⁹ the first of 41 cases appeared on the sixth day and the last on the twenty-second day.

The last case in the Camp Polk series did not show symptoms until 147 days after immunization. The extremes or "range" for these 1,004 cases include therefore 132 days. Measures of central tendency and deviations probably are concepts of greater utility. The mean incubation period for this series was 96.41 days. The "sigma," or standard deviation, was 16.14 days. In general, 68 per cent of the men involved should have an incubation period falling between 80 and 112 days (1 "sigma" above and 1 "sigma"

below the mean). In theory the number would have been 683; actually it was 708. Onset of symptoms, then, although deriving from a controlled dosage of etiologic agent given in the same place and at the same time to the same sort of men occurred, in point of time, along almost the entire course of a rather typical distribution curve.

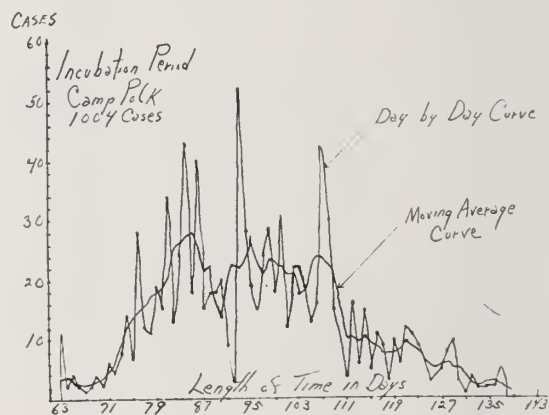


GRAPH 1. Actual values graphic representation of data in the 3 series discussed based on material presented in table 1. Double line—Iceland, Vaccine Lot No. 368, 516 cases; solid line—Fort Custer, Vaccine Lot No. 368, 377 cases; dashed line—Camp Polk, Vaccine Lot No. 369, 1,004 cases.

A graphic representation of the data in the Camp Polk series and for the men from Camp Custer is shown in graph 1.

In graph 2 the distribution of the Camp Polk data is further visualized by means of a day-by-day plotting smoothed off with a 5-unit moving average curve. It is obvious that when the cases are plotted on a day-by-day curve the graph will be a very irregular line. It is the custom to round off such graphs in various ways. One may consider the data on a 5-day or a 7-day basis and plot by units of corresponding magnitude. The 7-day unit has the advan-

tage in these data in coinciding with an administrative unit of time for making reports. The 3 curves shown in graph 1 have been constructed on the 7-day unit basis. Graphs are smoothed also by "moving averages," and in graph 2 this has been done utilizing a 5-unit average in which the value for each day is obtained by averaging the sum of the values for the day itself, 2 days before and 2 days after. It is significant that such methods may obscure points of interest. Thus in the day-by-day curve for Camp Polk, shown in graph 2, the regular recurrence at 7-day intervals of peaks probably indicates camp routines or soldier habits we need to know for a full understanding of the situation. From the



GRAPH 2. Vaccine Lot No. 369, Camp Polk, 1,004 cases, plotted in actual values on (a) day-by-day basis, and (b) as a moving average. Note recurrence of peaks in day-by-day curve at 7-day intervals.

table and the diagrams involving Camp Polk it will be noted that 159 men sickened in the 12th week, 138 in the 13th, 170 in the 14th, 137 in the 15th, and 134 in the 16th. What determined why one sickened in the 12th or in the 16th week, or not at all? All doses of infection were alike, all were given at the same time, and all subjects receiving them were approximately similar.

Further emphasis on the importance of the condition and environment of the host in determining the outcome of an infection is furnished by a study of the cases which arose out of the inoculation of several thousand men on February 21, 1942 at Fort Custer with vaccine

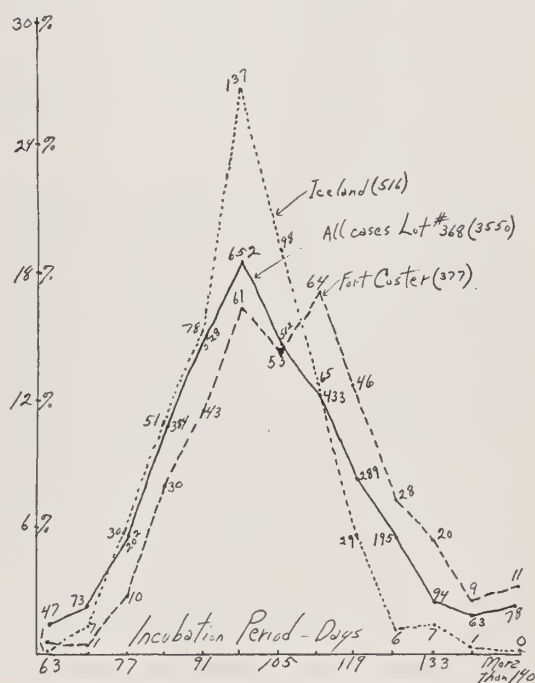
lot No. 368. Some of these men remained at Fort Custer, and 377 developed jaundice there. A number went to Iceland, and after arriving at that outpost 516 had jaundice. The data for these 2 groups will be found in table 1 and graph 1. In graph 3 the Fort Custer experiences are compared with the total experience with vaccine lot No. 368 collected from a study of the records of 47 camps and forts.

In graph 3 the curves are drawn from the percentage occurrence of jaundice concerned which it is thought may be more readily visualized than the representation to scale of the exact values which vary considerably in magnitude in the different experiences. The numbers placed on the curves in graph 3, in order to present full information, are, however, the actual count of cases which occurred in the time interval under consideration (7 days). The mean incubation period for the men jaundiced at Fort Custer is 104.72 days with a standard deviation of 16.60 days. For this group 68 per cent of the cases should have incubation periods falling between 88 and 121 days and actually 68.9 per cent of them do. For the Iceland series the mean is 95.79 days with a deviation of 10.31, and the 68 per cent limits are theoretically 85 and 106 days, within which limits we find 63.6 per cent of the cases.

It is believed there is significant difference between these 2 sets of data on mean incubation period deriving from an identical, activating experience in 2 lots of men, originally similar, later on diverging widely in experience and environment, although it should be admitted that the differences in incubation period appear to be greater than they are. We are dealing with a phenomenon which is extremely laggard in its evolution. Nine days in the life of a case of homologous serum jaundice is relatively less time than 1 day in the life of a case of yellow fever. Although mature consideration cautions moderation in evaluating the differences pointed out it would nevertheless seem unwise to disregard altogether these differences, par-

ticularly in such a relatively controlled series.

In conclusion, 3 rather extensive series of cases of jaundice in Army personnel following the administration of yellow fever vaccine have been studied from the records and reports available in the Office of the Surgeon General. It is believed that these outbreaks of jaundice offer rather unique conditions of control as far as the nature and "invasion" of the etiologic



GRAPH 3. The incubation period in days for all of cases from Vaccine Lot No. 368 studied and from 2 outbreaks at Fort Custer and in Iceland. Dotted line—Iceland, 516 cases; dashed line—Fort Custer, 377 cases; solid line—all outbreaks of No. 368 studied, 3,550 cases. Summed by weekly totals and actual values shown on curves but curves determined by percentage values to put all data on comparable basis.

agent are concerned and that such data should be put on record. The evidence would seem to indicate that we have not heretofore placed enough emphasis on the contribution of the host and his environment to the variability in case incidence, length of incubation period, and variety and severity of symptoms observed when a series of cases of exposure to risk of

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TREATMENT OF INFERTILITY IN MALES

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Washington

THE war has presented a most unusual opportunity to study the problem of infertility, by virtue of its many marriages and exigencies of impregnation before servicemen went overseas. With each decade there is an increasing responsibility placed upon the male in childless marriages. It is difficult to ascertain where this trend will stop.

Six hundred men were examined to determine this responsibility with the purpose of corrective measures where possible. A regimen has been instituted which has had no parallel in medical literature and is presented herewith for what it is worth. The routine in each case consisted of a history, physical examination and complete sperm evaluation, after which special tests were made when indicated. Important in the history is the duration of the apparent sterility, pregnancies by previous marriages, the use of contraceptives, diseases, operations, injuries and anomalies. Following the general physical examination with special attention to constitutional diseases, endocrinopathy and nutritional deficiencies, the genital system is examined minutely. The complete sperm evaluation is next in order and may be diagnostic within itself as to the underlying cause and as to prognosis. The ejaculated specimen is collected in a dry widemouthed bottle by coitus interruptus or by masturbation, and examined immediately (not later than 2 hours). The volume, pH, sperm count per c.c., percentage of active sperm, survival time and morphologic study complete the test. Less practical examinations were omitted. Special tests such as Rh determinations, B.M.R., blood tests, cystoscopic examination, testicular biopsy, X-ray films, etc., were made in appropriate cases.

Normal findings were revealed in about 10 per cent of the husbands referred and were excluded from this study.

The following table represents the average findings in the 600 cases:

	Before treatment	After treatment
Volume of ejaculate.....	2.2 c.c.	3.1 c.c.
pH of ejaculate.....	7.3	7.3
Sperm count per c.c.....	38,761,000	61,853,000
Percentage viable in 1½ hours.....	7.2	8.4
Endurance.....	2 hours, 31 minutes	5 hours, 15 minutes
Stained specimen.....	14.3 per cent abnormal forms; pus in 20 per cent	3.6 per cent abnormal forms; pus in 5 per cent

Average length of treatment for each patient was 3 months (2 6-week courses).

The type of treatment consisted of hormone therapy; use of the gonadotropic factor, 150 units, twice weekly, alternating with the use of chorionic gonadotropin, 500 units, twice weekly.* The prostate was massaged once a week, whether a prostatitis was present or not, for its stimulating and circulatory effect. All obvious pathology was removed when possible. A careful program of rest, diet, regulation of habits, and exercise was prescribed.

In 8 cases in which there seemed to be a nutritional disturbance, certain amino acids and vitamins were especially prescribed.†

Two hundred and seventy-three pregnancies resulted from the above. The unsuccessful

* Chorionic gonadotropin was supplied by Ayerst, McKenna & Harrison for part of this study.

† Arginac tablets, supplied by Ortho Research Foundation, consisting of arginin, lysine, tryptophan, calcium pantothenate, pyridoxine hydrochloride, thiamin hydrochloride and riboflavin.

327 were given careful scrutiny for factors accounting for failures.

Factors due to success are enumerated herewith. The sperm count was usually above 50,000,000 per c.c., and 50 per cent or more were active. There was only 1 successful case of complete aspermia treated medically. Oligospermia, where the sperm count was low but there were some spermatozoa present, seemed to have the most favorable prognosis. Reduction in the number of abnormal forms below 20 per cent invariably occurred. There was also a definite correlation between an increase in abnormal morphology and the wife's history of miscarriages. Pregnancies occurred in 6 cases in which husbands had a definite history of bilateral epididymitis and in 32 cases with unilateral epididymitis. Two patients had bilateral orchitis attending the mumps during childhood. One patient had tuberculosis of the right testicle, and the result was successful after a right orchiectomy. Prostatitis in some degree occurred in 96 cases. Urethral stricture was present in 22 cases. Twenty-three had febrile constitutional diseases within a year prior to treatment.

Ordinarily the volume should be 3 c.c. or better. This amount may be necessary to dilute the vaginal acidity to the proper pH.

The pH of the ejaculate was fairly constant at 7.3. Attempts to change this failed probably because the glands contributing the most toward the volume of the ejaculate are secretory and not excretory in function.

The endurance time of sperm activity was at least 5 hours in successful cases. This seems reasonable when the speed and distance traveled are reckoned with.

Analysis of unsuccessful cases revealed the following. A large number had a history of protracted febrile diseases, especially of the recurrent type (malaria, etc.). Bilateral at-

rophy of the testes following mumps was present in 19 cases. Gonococcal epididymitis was present in only 3. Sex habits were abnormal in 6 cases. There was undoubtedly a depression in the sperm reserve from excessive sexual activity in many. Renal pathology with hypertension existed in 2 cases. One of these patients was later found to have congenital polycystic kidneys, where the desirability of offspring is questionable. In 3 cases in which the sperm count and activity went down during treatment therapy was discontinued. Occupational exhaustion was present in 180 cases.

It has been assumed without scientific proof that a nonmotile sperm is not viable and is incapable of penetrating the ovum and consequently forming the zygote. This assumption may be false, since it is known that motionless sperm become active under certain conditions.

Significant in the successes was the increase in number of active sperm. Sperm with abnormal pathology have a direct bearing on miscarriages. Bilateral mumps has been over-emphasized as a cause of infertility. It apparently depends on the degree of testicular atrophy. Epididymitis is important only in rare cases. Prostatitis, urethral stricture, and febrile illnesses are factors pertinent to impaired fertility. Nutritional disturbances cause infertility and often can be corrected. Three out of 7 patients having nutritional disturbances responded to administration of amino acids and vitamins as described above. Penicillin had no effect on fertility, except in a few cases where there was a definite infection as a basis. Penicillin had no effect on sperm motility in vitro even in highly concentrated solution.

The prognosis in male infertility improves as knowledge unfolds on this highly interesting subject. Many factors remain unsolved. At present there is a 46 per cent chance of success.

ELECTROENCEPHALOGRAPHY IN CLINICAL PRACTICE*

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T HAS been known for many years that nervous tissue like collections of other living cells develops electric potentials. But these potentials are of such small magnitude that the development of modern radio instruments was necessary before satisfactory methods were available to amplify and record the electric phenomena emanating from the brain. In 1924 Hans Berger, a psychiatrist, after many years of laborious research, attached electrodes to the scalp of a patient and recorded the electric pulsation generated by the underlying cerebrum. Other investigators¹⁻⁶ have refined the technic, and radio engineering has provided a highly sensitive instrument, the electroencephalograph, which magnifies the potential variations many million times, thus furnishing us with a measure of cortical function.

The origin and mechanism of the electric wave patterns recorded in the electroencephalogram (known as EEG) is not fully understood, but it is the consensus that these brain waves represent the collective simultaneous discharge of hundreds of cortical cells that "pulsate" in unison. These electric phenomena apparently occur in the outer cortical layers of the brain, but many authorities feel that any collection of nerve cells may be the source of measurable potential variations, and that even subcortical epicenters of electric discharge may exist. Presumably each single nerve cell "beats" in a rhythmic fashion, but its individual potential is too tiny to be recorded. However, when

several hundred cells discharge synchronously, their cumulative effect when amplified produces a wave which reflects the physicochemical activity of that particular group of cells. The various wave forms have been classified by electroencephalographers into several arbitrary categories. The most frequent wave pattern in a normal EEG is a symmetrical, rhythmic sequence of waves that occur with an average frequency of 10 per second. The individual waves are smooth in contour and indicate voltage variations which range from 20 to 100 microvolts. This type of wave pattern has been designated by Berger as the alpha rhythm (fig. 1). It is most frequently observed in the occipital and parietal regions, although it may be present elsewhere in the brain. This fundamental alpha rhythm is modified by a multiplicity of factors and is best exhibited when the patient is in repose with a minimum of extraneous stimuli present in the environment. These large, smooth alpha waves become flattened or disappear entirely during mental activity or when such stimuli as pain, light or sound are applied. With the patient completely relaxed and under basal conditions, the rhythmic beating of the alpha rhythm may be compared to the idling of a motor when no "load" is applied.

Another important factor that influences this basic wave pattern is age. Before the age of 10 years, the wave activity is poorly organized, of high voltage but of slow frequency, with fairly irregular contours to the individual waves (fig. 2). As maturity approaches, alpha rhythm begins to occupy in increasing proportion of

* Read before the Section on Neurology and Psychiatry of the Society, March 1, 1945.

† On leave from the Medical School of Rosario, Argentina.

the record, the relative proportion of the alpha to the entire record being designated "per cent alpha." This latter index is a valuable means for estimating cortical activity. It tends to be fairly constant as long as the individual remains reasonably healthy.

the latter is in abeyance. Sensory stimuli do not suppress it, as is so characteristic with the alpha waves.

A third type of wave pattern, the delta, is characteristically found during deep sleep but is also present in cases of increased intracranial

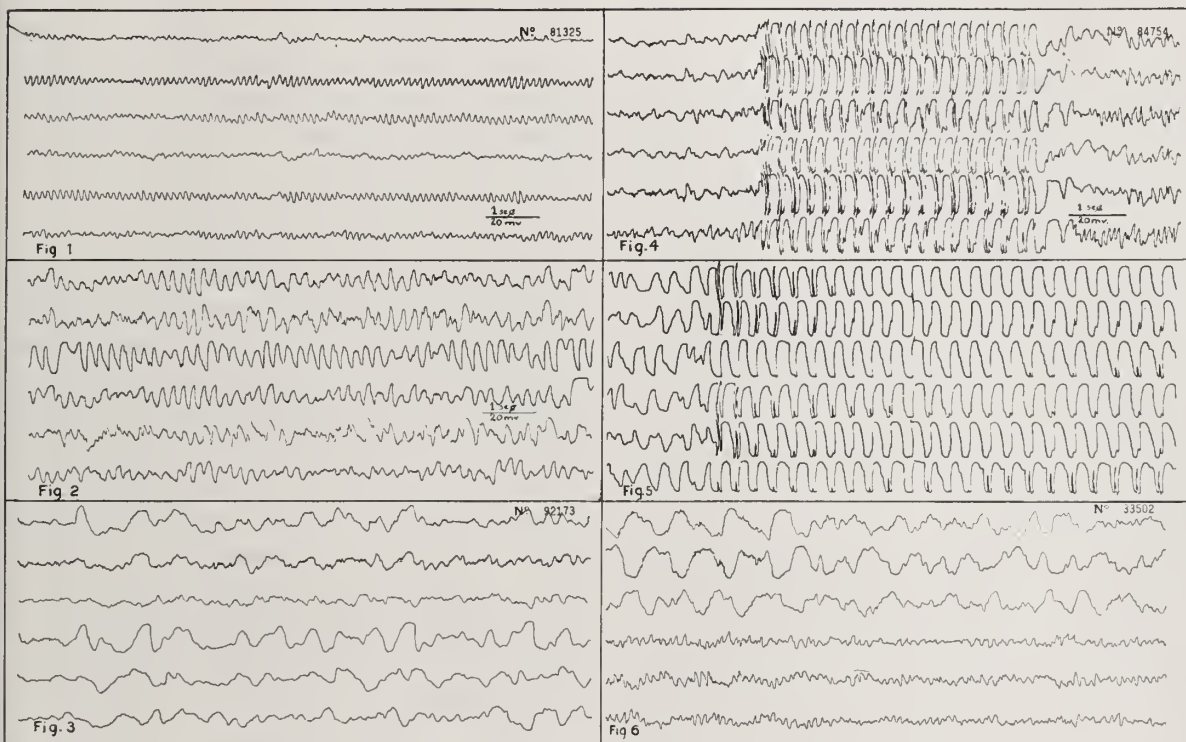


FIG. 1. Normal electroencephalogram. The tracings are from the right frontal, parietal and occipital areas (upper 3). Same areas from the left in the lower 3.

FIG. 2. Normal electroencephalogram in a 1½-year-old infant.

FIG. 3. Delta waves. In a patient with symptoms of diffuse intracranial pressure. The record also shows a left-sided preponderance.

FIG. 4. Petit mal attack.

FIG. 5. Record taken in between seizures, from a patient suffering from petit mal.

FIG. 6. Record taken from a patient with a right frontotemporal meningioma, surgically verified. The upper 3 tracings show phase reversal slow waves. The left side did not show any abnormality.

Another frequently observed wave pattern has been designated the beta activity. This wave form is lower in amplitude but of greater frequency, ranging from 18 to 30 per second, and like the alpha activity is found in all regions of the brain, but its highest incidence is in the frontal and precentral regions. This type of electric activity is often superimposed on the alpha rhythm and often can be observed when

pressure, coma, anoxemia or in other states in which metabolic activity is diminished. The "delta" frequency varies from 0.5 to 6 cycles per second. It is usually of high amplitude and is exhibited by a variety of pathologic conditions (fig. 3).

The electroencephalographer, in interpreting the tracings, measures these various characteristics of amplitude, frequency, regularity,

periodicity and symmetry, compares these features, and correlates the cortical activity of various parts of the brain.

EPILEPSY

One of the most important clinical contributions of the EEG is in the diagnosis, investigation and treatment of epilepsy. The EEG uniquely reveals the basic pathophysiology of epilepsy, throwing new and important light on this very common disorder. In fact, Gibbs, on the basis of exhaustive investigations, has described epilepsy as an "electrical brainstorm" and has suggested a new name for this old affliction, "paroxysmal cerebral dysrhythmia." Furthermore, there is convincing evidence to show that the convulsions and other epileptic manifestations are produced, or at least accompanied by, periodic, abnormal, excessive electric discharges in the cortex. These abnormal discharges sweep over the brain like a tidal wave, producing convulsions in its path in those parts of the body that are represented in the corresponding parts of the stimulated cortex.

The grand mal convulsion is quite easy to diagnose, but the physician rarely observes the seizure, and he accepts the word of the nurse, the relatives, or even the patient himself. Furthermore, seizures may be infrequent or of short duration, or they may be exclusively nocturnal. Even a most thorough neurologic examination is negative between attacks in idiopathic epilepsy. On the other hand, the EEG detects the vulnerability to seizures. The EEG is of further value in discerning epileptic proclivities in such subtle manifestations as petit mal, sensory-motor attacks, uncinat fits, psychic equivalents.

In addition to revealing the presence of a convulsive disorder, the EEG is helpful in localizing the epileptogenic focus. In some instances the more complicated procedure of air-encephalography is less revealing than the EEG, and it may effectively take its place.

There is no specific wave pattern that is

uniformly correlated with the various types of convulsive disorder with the exception of petit mal. In this disease a wave complex is very frequently found. It consists of a fairly periodical alternation of high spikes and slow rounded waves, known as spike and dome pattern (figs. 4 and 5).

In the scientific management of epilepsy periodic tracings are of great value, and some authorities recommend that it be used as a supplementary method of determining the efficacy of medication.

EEG AND LOCALIZATION

Neurologists and neurosurgeons have come to place increasing dependence upon the EEG as a laboratory aid in localizing focal lesions in the brain. It is accepted that an abnormal EEG may be produced by any space-occupying lesion (tumors, abscesses, cysts, hematomas), particularly if the lesion lies near the surface of the brain (fig. 6). Of course, the EEG cannot identify the pathology of the lesion, but in addition to localizing the lesion it is often a sensitive measure of its course and is occasionally more informative than the pneumo-encephalogram or even the ventriculogram.

BRAIN INJURIES

In brain injuries the EEG is valuable in localizing the site of the damage. It furthermore gives the most reliable objective evidence of the post-traumatic status of the brain. The EEG approaches normal as the effects of trauma resolve. In some instances, repeated EEG examinations may anticipate the development of a convulsive disorder. It is evident that this phase of electroencephalography finds a wide field of application in the management of war casualties.

RESEARCH

In the field of research the EEG is an invaluable instrument, e.g., in exploring the

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A NEW TECHNIC FOR ABDOMINAL PARACENTESIS

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ABDOMINAL paracentesis, as a means of removing fluid, is frequently a distressing experience to the patient and a tedious operation for the physician and nurse assisting. Furthermore, the decompression of the abdomen resulting from the rapid removal of a large quantity of fluid causes syncopal attacks, sensations of giddiness, paroxysms of coughing, and even prostration. The size of the needle and the time required to withdraw large amounts of fluid by the conventional method may result in psychic trauma to the patient.

To overcome some of these difficulties, the following procedure was devised, and has been found to be effective. The patient is requested to empty the bladder, or is catheterized when necessary. He is then made comfortable in bed or in a chair in a semi-upright position. The skin in the midline, midway between the umbilicus and symphysis pubis is infiltrated with a 1 or 2 per cent solution of procaine using a 26-gauge needle for the initial puncture. If the patient is obese, a 20-gauge needle, 1 inch in length, is then employed to infiltrate the subcutaneous tissue, abdominal muscles and

peritoneum. An 18-gauge needle with a beveled stylet is then inserted through the abdominal wall in the anesthetized area. The stylet is removed from the needle. As soon as the ascitic fluid comes through the needle it is connected to a Wangensteen apparatus. The fluid is collected in the usual manner. The flow of fluid is gradual and is usually continuous. Decompression is, therefore, slow and complete.

This procedure has been used 16 times in a total of 12 patients. In each case the patient was entirely comfortable throughout. As much as 12 liters of fluid have been drained over a 4-hour period without discomfort to the patient. The only attention required from the nurse was to empty the collecting bottle at intervals.

An additional advantage of this method is that fluid for cultures and other examinations may be aspirated directly through the sterile rubber connection.

It is believed that a more widespread use of this procedure will reduce the common inconvenience of abdominal paracentesis as practised in most hospitals today.

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effects of new drugs, investigating new neuro-surgical procedures, studying the effects of electric shock therapy, exploring the genetics of epilepsy, and in the entire expanding sphere of neuropsychiatry. Clinical neuropsychiatry has and will benefit abundantly by this new science of electroencephalography.

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President's Page

THE SPIRIT OF DEMOCRACY

This past week we had a meeting of the Chairmen and Vice Chairmen of the different committees of the Medical Society for the coming year. It was an unseasonably hot night, yet there was almost 100 per cent attendance and one could not help being thrilled with the interest and enthusiasm displayed. Brief reports were made by the men that head the committees on the plans that had been thought out and what they hoped to accomplish during the coming year. There was a spirit of democracy in the air—a spirit of effective good will of individuals giving up something for the common good. One could not help being pleased that our Medical Society's affairs are in such hands.

There was one note sounded in the report of the Vice Chairman of the Grievance Committee that caused some concern. Apparently there are many letters that come to the Medical Society's office with manifestly absurd complaints against different members. But by far most complaints have to do with excessive charges for professional services. Dr. William M. Ballinger, in the June number of the ANNALS, said something on this subject which was heartily endorsed by almost everyone that read it. Professional fees that are definitely out of line with services rendered not only cause embarrassment and work a hardship on the patient, but arouse the animosity of family and friends.

All of us present that night got the impression that this tendency to commercialize medicine was not widespread, but here and there it reared its ugly head and was doing not only a few men particular harm but all of medicine. It gives us grave concern both from the unfairness of the practice and the loss of good will that can react so disastrously to our profession.

We wonder how we can get through to this small group and make them sensitive to the heritage that has been cherished down through the years. When men or nations fail to make their actions square with ideals or what is fair and just, then history has shown that some force, some spiritual law, comes into operation and sweeps them aside, making way for a new order. It seems unfair that our entire profession should suffer through the action of this small group.

Wm. Earl Clark

Editorials

THE MATERNAL AND CHILD WELFARE ACT OF 1945

On July 26, 1945, Senator Pepper of Florida introduced S.1318 on behalf of himself and nine other members of the Senate Committee on Education and Labor to which the bill has been referred.

Appropriations for the first fiscal year ending June 30, 1946 are authorized to the extent of \$100,000,000, \$50,000,000 allotted to Maternal and Child Health Services, \$25,000,000 to the services for Crippled Children, \$20,000,000 for Child Welfare Services and \$5,000,000 for the expenses of the Children's Bureau in connection with its administration and for other purposes such as studies, demonstration, investigations and research, the training of personnel for Federal, state and local services, and the payment of salaries and expenses of personnel detailed at the request of state agencies to coöperate with and assist such agencies. After June 30, 1946, there is no ceiling placed upon appropriations for the purposes cited in the bill.

The very first clause in the bill states that its object is to provide for the "general welfare" which cloaks the legislation with respectable constitutionality from a Federal standpoint but the succeeding words authorize the *several states* to make more adequate provision for the health and welfare of mothers and children and for services to crippled children, "and for other purposes." Throughout the bill many inconsistencies appear relating to Federal and state responsibilities in connection with the proposed services, one such provision stating that the Chief of the Children's Bureau shall approve any state plan which fulfills certain conditions specified while a later provision in

the same title insists that the Chief of the Children's Bureau "shall formulate general policies for the administration of this title."

The gross inequity of the proposed legislative act is its discriminatory character in an attempt to sovietize one segment of the population and likewise a single segment of the medical profession, namely obstetrics and pediatrics, which would seem at variance with the first words of the bill claiming to provide for "the general welfare."

Senator Pepper has described the bill as "a modest beginning" but in the opinion of many physicians who have studied its provisions it is considered to be a flank attack on medicine in general and a method of stealthy infiltration camouflaged by the emotional appeal of the pregnant mother and the sick and crippled child in whose welfare all humane persons are unquestionably interested.

No means test or consideration of financial status is permitted under the bill but all services and facilities "shall be available to all mothers and children in the State or locality who elect to participate in the benefits of the program." In this respect the proposed bill does not exactly parallel the Emergency Maternal and Infant Care Act enacted because of the exigencies of war which the Congress provided should apply to the lower 4th, 5th, 6th and 7th classes of enlisted personnel in the armed forces, thus at least constituting a partial means test.

This bill does not indicate who shall be the members of the medical personnel concerned in providing medical services but uses the word physicians throughout and occasionally the word practitioners, which is a term applied to

cultists, Christian Scientists and other groups claiming to practice the healing art.

So far as compensation is concerned for physicians who provide medical services under the proposed act, it is insisted that payments to individual physicians be made on a per capita, salary, per case or "per session" basis (whatever that means), or in case of consultation or emergency visits on a fee-for-service basis, the latter, in the estimation of medicine, being the only equitable basis on which the laborer worthy of his hire should be paid for services rendered, as opposed to bulk or lump sum compensation.

While the bill insists on "high quality of care by providing for adequate remuneration for the persons and institutions providing medical care," thus linking physicians and institutions in the provision for adequate remuneration, the concluding clause (4) of this same section states, "purchase of care from public or voluntary hospitals and other health service agencies included under the State plan on a basis *related to cost* for providing such care." This would indicate that equitable compensation either to physicians or to institutions would not be achieved but that remunera-

tion to both would be a fraction of what is ordinarily regarded as the cost of medical care and such has been the experience in the past in nearly all relationships between compensation for medical and hospital services and municipal, state or Federal agencies who hold the purse-strings.

The bill excludes in section 103 a, (4) all working medical plans now in existence or to be later formed by physicians, Blue Cross or other private agencies by distinctly specifying that "the State Health Agency may develop agreements or coöperative arrangements with other State or local *public agencies* whose functions include the provision of service similar or related to the services furnished under the State plan."

Lack of space prevents further detailed consideration of the Pepper bill but physicians should study carefully an analysis of the bill prepared by the Bureau of Legal Medicine and Legislation of the A. M. A. which appears in the *Journal* of August 11, 1945, as in the opinion of many the enactment of this measure would presage the annihilation of the private practice of both obstetrics and pediatrics.

JOSEPH S. WALL, M.D.

PSYCHIATRY FOR PHYSICIANS

The current bulletin of the Washington School of Psychiatry, the training institution of the William Alanson White Psychiatric Foundation, contains announcement of a wide variety of courses and seminars on various aspects of psychiatry. Of particular interest to the readers of the *MEDICAL ANNALS* is one entitled Psychiatry for Physicians, directed especially to the practitioner who is concerned with the patient as a person and with the role that difficulties in living play in the development of somatic symptoms. A Seminar on Practical Psychiatry for Physicians is also announced, as is a lecture course on Basic

Psychiatry. These courses supply an answer to the problem of the physicians who are interested in the growing and important field of psychosomatic medicine. Further information may be obtained from the Executive Director, Dr. David M. Rioch, 500 West Montgomery Avenue, Rockville, Md.

The School also announces the William Alanson White Lecturer of 1945 as Major General G. B. Chisholm, formerly Director of Medical Services of the Canadian Army and now Deputy Minister of National Health of Canada. General Chisholm will speak on "The Reestablishment of Peacetime Society: Re-

sponsibilities of Psychiatrists." The lecture will be given on October 23, 1945 at the Department of Interior Auditorium, 18th and C Streets, N.W., Washington, D. C.

The work of the Foundation and the School is of especial interest to the many members of the Society who knew the late Dr. William Alanson White and who appreciated the significance of his position as the most eloquent interpreter in our generation of progressive psychiatric principles and their application to the problems of living.

The war, happily now ended, called force-

fully to public attention the importance of maladjustments at the level of interpersonal relations, whether these take the form of psychosis, neurosis, alcoholism, psychopathy, or psychogenic bodily disorder. The psychiatric problems of the peace will be no less important. The Washington School is rendering a valuable service in making available to professional people postgraduate opportunities in an important field, and in contributing to making Washington a significant center of psychiatric education and practice.

W. O.

WAR ON CANCER

Of all the diseases to which man may fall heir, cancer is the most insidious and devastating. It is definitely on the increase and if ignored is destined to become the generalissimo of grim reapers. In 1911 cancer was the seventh cause of death in the United States. Today it is "runner up," surpassed only by diseases of the heart. The increase in cancer is due in part to the fact that more people are living to the so-called "cancer age." This is not the sole reason, however, because cancer strikes young and old alike, although its greatest incidence is between the ages of 40 and 60 years. Regardless of the cause we must face the facts and begin now to call a halt. Today there are between 600,000 and 1,000,000 people in the United States affected with this disease and 1 out of every 5 persons now living who dies after the age of 40 will die of cancer. It has been estimated that 17,000,000 people living today in the United States will become victims unless this tidal wave is subdued.

The term cancer means a malignant growth, regardless of the constituent cell type. An unknown biologic change occurs in the cell protoplasm whereby growth becomes uncontrolled. Instead of the cells multiplying, becoming adults and functioning in an orderly

manner, they remain young and wander to unaccustomed parts of the body. They disregard all laws governing normal cell development, their sole purpose being multiplication. Under the microscope the individual cancer cell may resemble a normal cell. They are, however, wolves in sheep's clothing and the gangsters of cellular society. Left undisturbed, the cancer cell, regardless of its location, multiplies to form bulky masses. It replaces normal tissue, outgrows its blood supply, becomes necrotic, and sooner or later leads to death of the individual afflicted. Surgery, X-ray and radium therapy, if used early, offer our only hope of cure. Vaccines and serums have proved to be worthless and are the refuge of the destitute. Considering the meager funds so far expended on cancer research, remarkable progress has been made in our knowledge of the cause of this disease. At present scientists are agreed that there is no single cause, but a multiplicity of activating agents. Cancer is definitely not due to bacterial infection or to a parasite. The only thing parasitic about cancer, as Ewing has said, is the cancer cell itself. It simply divorces itself from the body laws and grows autonomously.

It is a mistake to say we know nothing as to

the cause of cancer. Research has shown that it can now be produced at will in lower animals by a variety of unrelated means. For instance, mice can be interbred to such an extent that practically 100 per cent will develop spontaneous cancer. Likewise, interbreeding will produce a strain which is practically resistant. This connotes a hereditary factor. Recently it has been shown that resistant strains of mice, fed milk from the breasts of susceptible strains, develop a high incidence of spontaneous cancer. The application of tar to the ear of a rabbit will produce cancer with regularity. The disease may also be produced in animals by the injection of certain chemicals, such as benzpyrene and methylcholanthrene or even excessive doses of female sex hormone. It may be transplanted with ease among animals of the same species.

As to the occurrence of cancer in man, we also have pertinent data. We know that cancer of the skin develops in Caucasians exposed for prolonged periods to the elements and direct rays of the sun. It also frequently appears in scars resulting from burns and X-rays. Chimney-sweep's cancer of the scrotum results from certain substances in soot. In Kashmir cancer of the abdomen is common in the tribes who carry the Kangri pots of live charcoal underneath their robes in winter for warmth. We know also that the clay pipe predisposes to cancer of the lip and faulty dentures and broken teeth to cancer of the tongue. Again irritation of a pigmented mole frequently leads to a most malignant type of cancer. Radioactive substances found in cobalt produce cancer of the lung among miners of Saxony, and a similar substance in paints used for luminous dials of watches causes cancer of the bone.

The most outstanding contribution to our knowledge of cancer was the growth in pure

form of both human and animal cells outside of the body. By the addition of cancerogenic chemicals to the nutrient media, normal cells will turn into cancer cells and will grow as a cancer when introduced into a normal animal. We have, therefore, methods of producing cancer outside as well as inside of the body. The investigator may observe the slow process whereby the normal cell changes its biologic character to become a cancer cell. This may point the way for the worker to reverse the process and change the cancer cell back to a harmless normal cell. Such an event would obviously lead to revolutionary methods of treatment.

Scientists have progressed just half of the way in conquering cancer. We know how to produce it at will. Our ultimate objective is to devise methods equally simple which will change the malignant cell back to its normal state. That time will come, but only with untiring research and a more comprehensive understanding of living protoplasm.

Funds available for this momentous task are a mere pittance, considering the gravity of the problem confronting us. Let us then unite our efforts, physicians, scientists and laymen alike, in the frontal attack on cancer. Funds are needed for the employment of competent scientific personnel, the erection of laboratories, purchase of equipment and supplies, and the establishment of cancer prevention clinics and treatment centers. These latter should be located in every medical school and approved hospital in the country. By waging such a concerted and coördinated war there is every hope of victory, a triumph that would mean the saving of hundreds of thousands of lives annually and the prevention of 17,000,000 persons in the United States alone from becoming victims of this disease.

R. M. C.

In and Out of Focus

BY THE OBSERVER

Army Recruiting of Physicians Termed "Antiquated System" There is ample evidence of a rising tide of discontent within the Medical Corps of the Army. An illustration of this is a letter from a group of medical officers which appeared in Cedric Parker's syndicated column, "In This Corner."

"The medical profession responded most generously when our country needed their services. After a few months in service, it became painfully apparent that the number of doctors needed, as set down by the Surgeon General, was a gross overestimate. Disillusionment became more complete as the months and the years passed by. It's no idle talk that the vast majority of doctors in the service have led a very leisurely existence. It is and has been very common to have less than two hours of work a day. This condition has prevailed in the majority of army hospitals for over a year. The situation is especially bad for doctors used to an energetic and busy civilian life. When we hear of the 'crying need' for doctors and more doctors we become enraged beyond words. Our bitterness and disgust find outlets in letters to our congressmen. How futile are those letters . . .

"What the sequelae will be as a result of this shortsighted, stupid attitude of the authorities toward the medical profession is hard to say. This much is certain: It will be next to impossible for the Army, the Navy, the United States Public Health Service, the Veterans Administration to obtain able doctors after the war. The pay, the politics, the poor professional associations are enough to make any doctor shudder. Look at the artful defenses of the regular Army against the charge it has hoarded doctors. They'll tell you of the huge number of patients in army hospitals. But understand this: Patients in convalescent hospitals are still counted as bed patients even while they're home on convalescent furloughs up to 90 days. New-born babies are counted as regular patients. Uncounted thousands of ambulatory cases are retained in hospitals long after they're ready for discharge. Some hospital commanding officers instruct their admitting officers to pack hospitals with patients. Cases are brought in for observation and prolonged treatment of minor conditions . . .

"All these facts are true. And yet the Army still desires a ratio of one medical officer to every 165 men.

We hope you'll find room for this expression and lend your efforts to aid an honorable profession from being degraded by military politics. For obvious reasons we desire our names deleted if this letter is published."

Are such complaints justified? Last month Colonel W. Paul Holbrook, formerly President of the Arizona State Medical Association and now a member of the War Department General Staff, appeared before the Senate Military Affairs Committee for whom he had investigated the use of doctors by the Army. Colonel Holbrook observed that the Medical Department of the Army had at its disposal the best that American medicine had to offer, pointing out the great strides made by the medical profession in the last quarter of a century.

"Unfortunately," Colonel Holbrook said, "our Medical Department entered this war with almost exactly the same plans that were utilized during the war of 1917-19. These were accepted without revision in light of the military experience and medical advancements of the succeeding 20 years."

He said an attempt had been made to staff all hospitals on the same scale as was used for a 100,000 man peacetime army, there being no change in ratio of hospitals to troops. "With the rapid transportation available," Colonel Holbrook commented, "it is difficult to justify the staffing of all hospital beds throughout the world with medical personnel on this basis when our civilian population was being neglected and the future of American medicine was being jeopardized."

According to an article appearing in the *Washington Post* on September 19, Colonel Holbrook listed four fundamental fallacies in the present-day medical tactics:

"1. That the doctor is comparable to the fireman—you do not need him all the time but he must be there when you do.

2. That the doctor in the hospital is an inseparable part of the beds, equipment and physical properties and that he remains with that hospital as a part of it whether there are any patients or not.

3. That the numerical strength of military units is the determining factor in arriving at the number of doctors required.

4. That the doctor must be first a medical officer and second a professional man."

As for the waste of medical manpower, Colonel Holbrook said that fifty doctors assigned to a 15,000 man infantry division is "far too many for simple medical care and preventive medicine of a group of healthy young men" yet "far too few to care for the medical requirements of the division in battle." He emphasized that these doctors are permanently assigned to a division regardless of whether it is in constant action or on inactive service. He reminded the Committee that the Army requirements for doctors would be greatly reduced if the principle of mobility were adopted. "Nowadays there is no reason why a surgeon should not operate one week in New Guinea and the next week in Italy."

Colonel Holbrook stated that the health of civilians was dangerously threatened when the armed forces took 60,000 doctors to care for 12 million men and left 90,000 for the 120 million civilians at home. He added, however, that the Army is now doing a satisfactory job of releasing doctors. About 17,000 are expected to be returned to civilian life by January 1, or a 3,000 increase over an earlier estimate. He called attention to a matter which has long been of concern to the medical profession, that is, the threat to American medicine because of the drafting of premedical students.

Finally Colonel Holbrook urged the need for a Minister of Health or some Cabinet official whose concern is national health. He proposed that the military medical services be placed under his direction. He favored a nation wide health insurance program under which benefits could be extended to most of the population; suggested the gradual elimination of veterans' hospitals, and the extension of health insurance benefits to

veterans, they being given free choice of doctors in their own communities.



More Heat than Light

On an evening late in August, your Observer was sitting with his wife in his study listening to the radio while playing a few hands of cards. Undoubtedly this scene could have been duplicated that night in thousands of homes. When the hour of 9:30 arrived, he tuned in on the American Forum of the Air, recalling that there would be a discussion of the subject, "Should We Have Compulsory Federal Sickness Insurance?" As he and his wife listened, they wondered if the speakers on the Forum made the same impression on other listeners as they did on them.

To begin with, they were struck by the belligerent attitude of the participants. It was also evident that this was a battle of wits rather than a serious effort to present honest differences of opinion. From the very beginning, ill feeling was apparent. Perhaps this can best be shown by quoting some of the dialogue between the participants who, by the way, were: Dr. Morris Fishbein, Editor, Journal of the American Medical Association; Dr. E. J. McCormick, member of the Council on Medical Service and Public Relations; Mr. Nelson Cruikshank, Director, Social Insurance Activities, American Federation of Labor; and Dr. Ernst P. Boas, Chairman, Physicians' Forum.

Considering the important issues involved, one would think that acrimonious discussion of personalities might have been omitted. Apparently the debaters could not restrain themselves in this respect. Here is part of what they had to say:

DR. FISHBEIN: Mr. Cruikshank, you know Dr. Peters has never practiced anywhere but on a full-time salary in a university hospital. He has never really been out to see where practice is done among the various laboring groups.

MR. CRUIKSHANK: Yale University seems to think he is good enough to teach the boys up at Yale School.

DR. FISHBEIN: That is right; a very good teacher and a very poor practitioner of medicine . . .

Later, Dr. Boas, who was patently in disfavor with his colleagues on the program, came to Mr. Cruikshank's assistance.

DR. FISHBEIN: Mr. Cruikshank, . . . Are you, then, also in favor of compulsory taxation of labor in order to provide labor with housing, food, fuel, and clothing? . . .

DR. BOAS: Your question implies that people should be entitled only to the medical care that they can afford to buy, not to the medical care that they need.

DR. FISHBEIN: I never implied anything. I asked a direct question. Don't read into what I say any implications that are not there.

DR. BOAS: You intimated that, since everybody can't buy the same amount of bread or beef or the same type of housing—

DR. FISHBEIN: I did not so intimate, Dr. Boas. I said that a certain minimum amount of food, fuel, clothing, and shelter are necessary to life. Why should not we then have compulsory insurance to make certain that everybody in the United States has that minimum of fuel, clothing, food, and shelter?

MR. CRUIKSHANK: We do to a certain extent, and we support it. We support public housing programs.

DR. FISHBEIN: Do you make certain in the United States today that every person will have a minimum of housing accommodations?

DR. BOAS: Wouldn't you like to make certain of that, Dr. Fishbein? It would be a good thing.

DR. FISHBEIN: We haven't any such thing. Everybody knows that. All housing is still on an entirely different basis.

There followed a heated debate on the significance of Selective Service rejections, Dr. Fishbein taking the position that standards which he said he had helped prepare were high and only a basis on which to select men for the armed services. The impression which he gave was that this country was not too bad off physically even in the face of these rejections.

Later the participants returned to Dr. John Peters.

DR. FISHBEIN: . . . You quoted just a few moments ago from John Peters. Did you look at the date on that quotation from John Peters? Does John Peters know that the American Medical Association has developed a complete program which it is offering to the people in

order to make sure that everybody in the United States shall get proper medical care?

MR. CRUIKSHANK: Sure, John Peters knows it, because the date was August 27, 1945.

DR. FISHBEIN: John Peters probably wrote that long before August 27, because with that little group of thinkers that he assembled around him, it probably took him four months to get that out.

DR. BOAS: Dr. Fishbein, that last remark about Dr. Peters is quite ridiculous. First of all, Peters has not got a group of—

DR. FISHBEIN: Little group of thinkers.

DR. BOAS: He has some of the leading clinicians in the United States, and they are not all pure university professors, a group whom you seem to have contempt for.

MR. CRUIKSHANK: You are not from Harvard, are you, Dr. Fishbein?

DR. FISHBEIN: No.

MR. CRUIKSHANK: Which might account for that.

Then the question of Dr. Boas's political convictions was raised by Dr. McCormick.

DR. MCCORMICK: Dr. Boas, could I ask you a question? I hope you won't be offended. I read somewhere that you were affiliated with some 12 or 13 communistic organizations. Is that true?

DR. BOAS: No, it is not true.

DR. MCCORMICK: I am glad to hear it. Could I ask you a question? I am interested in the moral issues that we have to consider in the Wagner-Murray-Dingell Bill. Recognizing the fact that in countries where medicine has been regimented, the standardization of medical treatment is usually attempted, what reaction may we expect from various Christian denominations, Catholics, and Jews, who interpret the moral law to mean that life is sacred and given by God, when some government bureau decides that no women with certain diseases shall bear children, or that certain individuals may not marry—

DR. BOAS: I don't know why you mention that. It is completely irrelevant.

DR. MCCORMICK: Just a minute, please. Let me finish my question. —or that certain people must be sterilized or that others hopelessly ill shall have their lives terminated? That is a fair question, because in countries where medicine has been socialized all or some of these practices have been advocated and ordered, and here in America already we have birth control clinics and sterilization leagues.

MR. CRUIKSHANK: That is a ridiculous argument, Dr. McCormick.

DR. MCCORMICK: There is nothing ridiculous about it.

MR. CRUIKSHANK: That is one of these things where you start in that you are going to do this, and the next step follows, and way down the line the king's whiskers will be cut off or some horrible thing will happen that doesn't have anything to do with the subject.

The British Medical Association also came under discussion.

DR. FISHBEIN: And incidentally, Mr. Cruikshank and Dr. Boas, I am in constant communication with the leaders of the British Medical Association, and I have in my briefcase at present a statement from a member of the Governing Board of the British Medical Association, who says they are very rapidly nearing now in Great Britain a point at which the medical profession will have to discontinue its attempts to obtain from the British Government anything resembling a system that would enable them to provide a high quality of medical service.

MR. CRUIKSHANK: I have one in my briefcase that says they don't like the way you misrepresent the British health insurance system.

DR. FISHBEIN: Just a moment. We have a question of argument here. If he has it, I want to hear the name of the British official who wrote him that statement, because I can obtain from the British Medical Association an exact evaluation of the statement. All we need now is to have the name of the British official who made that statement for you—a member of the British Medical Association.

MR. CRUIKSHANK: G. C. Anderson, C.B.E., M.D., LL.D., F.R.C.P., Secretary of the British Medical Association.

DR. FISHBEIN: That G. C. Anderson died exactly 18 months ago, and he is in no capacity at present to represent the British Medical Association.

MR. CRUIKSHANK: He wrote this communication before he died, Dr. Fishbein.

DR. FISHBEIN: I happen to have known Dr. Anderson personally. He died exactly 18 months ago. He has now been succeeded by Charles Hill.

DR. BOAS: Yet, he published that statement in the *British Medical Association Journal*.

DR. FISHBEIN: Other men publish statements in their journals.

DR. BOAS: He was very indignant as to the misrepresentation of the British system that appeared.

MR. CRUIKSHANK: Do you want me to read the statement? You don't want me to read it.

DR. FISHBEIN: You can read anything you like if Mr. Granik gives you the time. It is immaterial to me what you read.

DR. McCORMICK: I don't think we ought to read statements, Mr. Cruikshank. . .

So far as your Observer is concerned, nothing is gained by such discussion. It certainly does not lend dignity to the position taken by the medical profession. After all, there is really only one vital issue at stake. How can physicians best serve the people of this Nation where their health is concerned? Organized medicine has definite ideas as to how this should be done. Let its leaders present them dispassionately. If its position is sound, there should be public support for it. In the final analysis, medicine's future rests with the people.

Undoubtedly the participants in this debate put on a good show for some listeners, but many thoughtful ones must have been chagrined.

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Pilots Have Phobias

To the groundling it is not surprising that pilots develop phobias. Fear often envelops him at the thought of flight, whether it be at tree-top level or in the stratosphere. However, phobias in pilots from the psychiatrist's point of view are another matter.

In thumbing through medical publications coming to his desk, your Observer recently came across an illuminating and highly interesting article appearing in *The Military Surgeon* for August, 1945, entitled "Phobias in Pilots." The author of the article is Major David B. Davis, Medical Corps, Army of the United States.

"One of the primary instincts in the newborn," Major Davis writes, "is the fear of falling, a fear that usually remains with the individual throughout life. This basic fear is one of the pilot's most important psychological problems. Much has been done to improve safety measures designed to help overcome this specific fear. Mechanical parts of planes have been gradually improved; fliers have been instructed repeatedly regarding safety measures, and it is well known that parachutes are being studied constantly for the purpose of increasing safety. Most pilots flying within the United States have developed such a sense of security because of the wearing of the modern parachute that they have little fear of having to 'bail out.' They feel that if it is necessary to

leave the plane and float to earth in a parachute they will land in comparative safety and soon be found.

"Anyone who examines fliers for the first time is amazed at their feeling of security. Frequently, however, pilots who have flown in this country or in foreign service are referred to the station hospital because of fears developed in certain specific situations in flying. The increasing numbers of these cases compels a more extensive investigation of the psychodynamics of such phobias.

"Studies of pilots show that phobias do not recur irrespective of environmental situations the way obsessions do. Phobias in fliers are present in specific situations only and act either as simple protective mechanisms or as substitutive phenomena for more deep-seated and disturbing personality conflicts. The phobia frequently is relatively simple in structure while the underlying conflict is complex and often difficult to analyze."

Major Davis says that one of the most frequently observed phobias in pilots in the continental United States is the fear of high altitude flying. Some are deeply troubled by the thought of bailing out over an area where there is slight possibility of rescue. For example, flying over desert, the pilot might be forced to land and his life be placed in jeopardy before he is rescued.

"To allay fears of such situations," Dr. Davis observes, "fliers are provided with small hand books containing information on the making of fires, methods of obtaining drinking water and the securing of food from use of local plants or animals."

One is not surprised to learn that flying over the ocean to escort a convoy to shore is another hazard which sometimes results in a definite fear. Early in the war, fighter plane pilots were well aware that mechanical difficulties which cause engines to fail over water meant almost certain death before a rescue could be effected. They carried no rafts, extra food or water, and their lifebelts would not keep them afloat indefinitely. Now they are equipped with a one-man raft in the parachute seat, extra rations and other essentials. These have lessened the fear of flying over the ocean, particularly over the North Atlantic.

There is the phobia of flying over mountains.

Some pilots become convinced that if they must land by parachute, they will be injured severely because of the type of terrain, or land in an inaccessible spot. "This phobia," Major Davis says, "is seen most frequently in fliers who are on foreign service and flying over mountains which are unfamiliar to them."

He mentions also the fighter, bomber, or transport pilot who is grounded because of his phobia of planes. In only one instance was a fear of closed spaces noted in the study of pilots.

"All phobias observed in pilots," Major Davis states, "have been related to situations of danger. This is in accord with the present understanding of the nature of phobias; for, as stated elsewhere, phobias are always associated with anxiety. As Freud pointed out, all symptoms of anxiety tend to remove the individual from situations of danger. The phobia and the anxiety remove the pilot from situations of danger inherent in flying, although the phobia is often brought about by personality problems that are totally unrelated to flying."

"... It has been known for a long time that fatigue and gradually increasing stress and strain tend to cause anxiety and hence phobias. Especially is this true when there is no immediate outlook for relief. In the early part of the war when fliers were few in number, it was necessary to keep them in one field of operation for long periods of time. This apparently unavoidable condition caused many pilots to develop phobias and anxiety because of the constant thought of danger without sufficient time away from the source of such thoughts."

Three methods of treating these phobias advocated by Major Davis are: In milder cases, remove the phobia by analysis and explanation; where chronic anxiety states exist, make a more thorough and discerning analysis; and, finally, eliminate the officer from the flying service. "Simple measures known to be of value in the mild and moderately severe phobias," Major Davis says, "are sufficient rest and recreation."



The President's Health The recent appointment of Colonel Wallace H. Graham as President Truman's personal physician has served to focus attention on precautions taken to safeguard the Chief Executive's health. At no time in our history has the head of

this Nation been burdened with so many responsibilities as at present. The least this country can do for its President is to afford him the best medical service it has to offer.

Only very recently there was much to do about the succession to the Presidency in the event of the death of the incumbent. President Truman himself faced this matter squarely and suggested to the Congress that provisions should be made for a successor who had been elected to high office by the people. However, Congress has not deemed fit to act upon his suggestion.

A more serious aspect of this matter was discussed by the *Washington Post* on September 6. The *Post* editorialized as follows:

"The Chief Executive is under unrelenting pressure from the very nature of his office. His health must be constantly guarded to avoid dangerous lapses in the essential service that he renders. The astonishing fact is not that a personal physician is allowed him but that no provision is made to tide the Nation over periods when the President may be incapacitated.

"Recent experience indicates that the country cannot expect complete information on the President's health from his personal physician. The chief duty of that expert is to keep the President well. When everything possible has been done to that end, however, the national interest remains unsatisfied. It demands that precautions be taken against every contingency. The facts of life constantly remind us that men may break down under the pressures of exacting work. And when that happens to the Chief Executive the Nation is left in a sorry status, for there is no machinery by which incapacity on the part of the President to meet his obligations can be determined.

"President Truman has been forthright and realistic in asking Congress for a new presidential succession law. He could render the Nation another great service by making equally candid recommendations on the subject of presidential incapacity. Perhaps the answer is a medical board to make an official determination, in the case of grave illness on the part of the President, that he is unable to perform his duties. Then the Vice President or other succeeding officer could temporarily step into the breach and save the Nation from helpless drifting in a critical period. If that is deemed too great a responsibility to be entrusted to a medical board, it could be assigned to the Supreme Court or a special board including the Chief Justice and the Surgeon General.

"The important point, in our opinion, is to have some

well respected body constantly available to make such a finding if it should prove necessary in the national interest. Mr. Truman can make a real contribution to the stability of the great office which he holds by asking Congress to close this avenue to chaos."

Your Observer agrees that steps should be taken now not only to safeguard succession to the Presidency but to relieve the Chief Executive if he becomes physically or mentally incapable of fulfilling the duties of his office. Unfortunately there are no indications that Congress will act until it is faced with a crisis. Then the consequences may prove serious indeed.



Doctors, like others, have speculated on President Truman's political views. Does he lean toward the right or is he left of center? There are those who insist that the President is at heart a conservative. To prove the point, they call attention to several of his appointments. But those who say he is to the left of center point with equal assurance to appointees with decided liberal tendencies. They remind the hopeful conservatives that immediately after taking the oath of office, the President announced that he would adhere to the late President Roosevelt's policies.

One would think most of the conjecture would come to an end following the President's message to the Congress on September 6. Doctors, it would seem, would at least be convinced of the President's leftist inclinations. However, your Observer has talked to a number of physicians who do not yet believe what should be clear to anyone: that the President intends to fulfill his pledge to carry out his predecessor's policies. In his message he makes numerous references to the health of the people. The following quotations are those which are of special interest to a majority of the medical profession.

In discussing full employment, the President called attention to the late President Roosevelt's statement: "In our day these economic truths

*"... Adequate
Medical Care
for All
Americans..."*

have become accepted as self-evident... Among them are: ...The right to adequate medical care and the opportunity to achieve and enjoy good health. The right to adequate protection from the economic fears of old age, sickness, accident and unemployment."

Commenting on "these economic truths," President Truman said, "I shall from time to time communicate with the Congress on some of the subjects included in this enumeration of economic rights. Most of them, in the last analysis, depend upon full production and full employment at decent wages."

At other points in his address, the President dealt with Federal grants to states and the construction of hospitals and medical centers throughout the country. He also dealt with medical care and hospitalization for veterans.

In concluding his message, the President makes this statement: "I shall shortly communicate with the Congress recommending a national health program to provide adequate medical care for all Americans and to protect them from financial loss and hardships resulting from illness and accident. I shall also communicate with the Congress with respect to expanding our social security system and improving our program of education for our citizens."

President Truman leaves no doubt that he is going to recommend a comprehensive national health program. So far as your Observer knows, no official or group of officials of the American Medical Association or its constituent societies has been consulted with regard to plans which he has in mind, nor has there been any indication that they will be consulted. Time alone will tell if there is to be a meeting of minds, which there certainly should be.



*Must We Be
Combative*

Pick up any medical journal and one usually finds some such phrase as "we must combat." It is the war cry of most medical editors urging

their readers to oppose socialized medicine, radical changes in medical practice, and further expansion in the field of medicine by the Government.

In the opinion of your Observer, the reaction to this belligerent attitude is, to put it mildly, regrettable. Of course, we must defend the things for which we stand and, if necessary, we must be willing to fight for them. But persistent combativeness becomes a little tiresome. It is therefore not surprising that people ask: If the medical profession is so opposed to what the Government or some agency is trying to do to improve the health of the people, what are they prepared to do themselves?

The truth of the matter is that our combativeness, even if successful, will not settle matters indefinitely so far as medical care is concerned. There are inadequacies which must be met. Physicians know this to be a fact, many lay leaders know it, and so do an increasing number of ordinary people.

Neither the laity nor the medical profession like some of the proposals which have been made. Certainly, medical service would deteriorate under some of the systems proposed and would not be acceptable to recipients or physicians. But this does not alter the fact that changes are in the making. Along with their combativeness, physicians must be willing to join with the Government and serious-minded people in seeking a healthier America.

The day when physicians considered themselves set apart from those engaged in other pursuits is gone with other types of isolationism. They might as well face the fact that medical care is now the concern of everyone. Some of our medical leaders do not act as though they believed that. They are disdainful of "lay interference," although people of undoubted intelligence and understanding have concerned themselves with health matters. Such an attitude can only be deplored. If the medical profession acts wisely, it will look at the health picture objectively, discuss the controversial

issues dispassionately, and seek the coöperation of interested laymen. Only by this means will a common ground be found.

Mention should be made of the importance of the medical profession's relationship to the Government. This must somehow be improved. At present medical organizations are more frequently than not ignored. Very seldom is their advice sought. Here is something which should be remedied without delay.

Your Observer believes that the combativeness of medical men who are disinclined to discuss anything pertaining to medicine with "outsiders" has contributed largely to this state of affairs. They should be warned that they are playing a dangerous game, one which may lead to disaster. "Pride goeth before destruction and a haughty spirit before a fall."



New England Medical Societies Organize New England medical societies are to be congratulated on the forward-looking program which they have just adopted. With no intention of offense, your Observer was pleasantly surprised when the doctors of conservative New England showed themselves to be genuinely progressive. He had accepted as a fact what is commonly believed to be true, that the East is staid and less progressive than the West.

At any rate, in its August number, the *Rhode Island Medical Journal* announced the organization of the Council of the New England State Medical Societies. Largely responsible for the establishment of the organization was the Rhode Island Medical Society which, through its House of Delegates, initiated the project.

Representatives of the New Hampshire, Vermont, Massachusetts, Connecticut and Rhode Island state medical societies assembled in Providence July 18. According to the *Journal*, "The group drafted a code of operation whereby the Council would serve as a fact finding, deliberative body to serve the medical profession of New England. The present authority of each State Medical Society, as well as its

relations with the American Medical Association, are in no manner to be disturbed by the new Council."

The aims of the proposed Council are stated as follows: "The main purpose of this Council is to bring about a closer coöperation between the State Medical Societies in New England in the development and maintenance of the highest standards in the conduct and administration of medical care, in the development of plans relative to the better organization of medicine, and in the furtherance of plans to improve the health of all the people in the New England states." It is made clear that the Council does not intend to deal with "those large matters in which all of the State Medical Societies are equally concerned. . . nor shall it seek to supersede the control now exercised by the governing bodies of each respective State Medical Society, nor by the House of Delegates of the American Medical Association."

Your Observer has long felt it would be desirable to develop a similar organization in the Mid-Atlantic states. For example, the state medical societies of Maryland, New Jersey, Pennsylvania, Delaware, Virginia, West Virginia, and the District of Columbia have much in common. In his opinion, progressive New England has blazed a trail that this and other groups of state societies might well follow.



Ways of Peace

Those of us who have relatives in the armed forces overseas have little conception of the let-down after the cessation of hostilities. It is, our soldiers tell us, as if they had been plunged into a vacuum. All the reasons for their being in the services have ceased to exist and there is little incentive to carry on. Naturally, their thoughts turn homeward, and they long more than ever for those they love. They are apprehensive, too, about the difficulty of reëstablishing themselves and making the adjustments necessary.

How different it is for us at home. Here we, too, have been busily engaged with the war.

Physicians, for example, have served on Selective Service examining boards, on committees of the Office of Civilian Defense, on the Procurement and Assignment Committee or some other board or committee. In addition, their practices have doubled, in some cases trebled. Now that all this has come to an end, or will rapidly do so, adjustments are in the making. Fortunately we are not at loose ends like our physicians in the services. For we can "convert" to peacetime without delay. We enter immediately into the postwar world with comparatively little disturbance to our existence. But we, like the others who will soon return to us, must design our plans for the new era.

This was emphasized at a meeting of the Chairmen and Vice Chairmen of committees of the Medical Society of the District of Columbia held on September 10. It may be of interest to the membership to know something about this meeting, which is an annual affair. The purpose of it is to discuss plans for the ensuing year and familiarize new chairmen and vice chairmen with their assignments. As can readily be seen, an opportunity is afforded participants to discuss the many important issues before the medical profession and to obtain a bird's-eye view of the Society's activities.

Many of the Medical Society's peacetime activities have had to be abandoned during the war. For example, an ambitious health education program was well under way before Pearl Harbor but had to be discontinued. It can now be undertaken again on an adequate scale. Even the scientific program was curtailed, although the ANNUAL SCIENTIFIC ASSEMBLY was presented every year except the last. This, too, will be remedied in the coming year. Incidentally, attendance should improve, for physicians will have more time to attend meetings because an increasing number will share patients. Finally, medical practice, which remained static during the war, is undoubtedly in for some modifications. In so far as the District is concerned, these can be guided to a considerable extent by the Medical Society.

So there is every opportunity to make the first postwar year auspicious. If interest is an important factor, certainly the meeting of the Chairmen and Vice Chairmen just held augurs well for the future.

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"In Short . . . in for a good spanking at the Modern Pharisees" hands of the *Tucson (Ariz.) Daily Citizen*.

"It has become quite an American fashion," the *Citizen* says, "to seek new political remedial agents which when adopted usually fail to remedy." The War Food Administration and the Office of Price Administration, the prime target of the foes of bureaucracy, are cited as examples.

"There are other of these war agencies," the *Citizen* continues, "that have been guilty of disservice to the citizenry because of plain dumb executives with a yen for regulations of all sorts."

But what stirred the *Citizen's* ire most of all was what is "commonly known as socialized medicine," which, it says, is "discussed ardently by agile planners who favor communal living and hate the profit motive for what reason they do not know. Most of them live well on the tid-bits of the very unfortunate masses whom they self-appointedly represent. They are paid to foment distrust rather than to cure the sick. They are sure that our physicians are gentlemen equipped with heated tongs who torture the poor for pay—very high pay.

"They do not like the term 'socialized medicine,' so they call it insurance. They assume that once the direction of 'healing the sick' is a governmental responsibility disease and ill-health will disappear like dew before the sun. What they would really say if they were quite frank in their advocacy of this latest communal effort is that it would provide job upon job for social workers; case upon case for indifferent and illtrained nurses; hospital management under the direction of inexperienced business managers and a host of unambitious physicians and surgeons seeking a 'life pension' as the top unit of this communal enterprise."

The *Citizen* finally winds up and lets go with this one:

"They [the planners] are the lads that crowd the temple steps and shout their goodness to the multitudes. For acclaim merely? Not at all. They are professional operators for pay; exhibitionists of a sort who always allure weak and equally hypocritical politicians to their side and for whose adulation they are presumed to PAY in votes. In short, they are the modern pharisees. They will orate on human misery at every opportunity, or without it, and glibly recite percentage figures that will make one shudder. But they never produce living proof of their assertions."

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Can They Count on You?

Previously in this column your Observer has emphasized the seriousness of the shortage of office space for returning service physicians. Conditions have improved very little in recent weeks. A letter was sent to members of the Society on August 27, informing them of the urgent need for their coöperation in solving the most critical problem confronting our homecoming veterans. Responses so far have not been numerous, 29 having replied on the forms enclosed with the communication. However, these few were most encouraging. Several physicians volunteered to share offices; others indicated the manner in which office space might be obtained; still others promised to stagger their hours so that another returning veteran could use their offices. The tone of the replies was encouraging, too. However, there should be many more among our members who could be of help and it is to them that this appeal is directed.

If you can do anything at all in the way of providing space for your returning colleagues, reply promptly. Do not file your form away, thinking that at some later date you will give it attention. Now is the time to let the Committee on Service Physicians know that they can count on you.

As pointed out in this column last month, our veterans should be coming home in greater numbers very soon. In fact, the War Department's recent announcement makes this almost certain. Already several Washington medical

officers from the Pacific area have been discharged on points. Fortunately, most of them have found offices. However, the demand for office space will increase rapidly.

If you have or know about office facilities that some veteran can use, fill out and return your form at once. The Society is counting on every member's coöperation.

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Geriatrics as Old as Medicine

The medical profession is frequently presented with something ostensibly new only to discover that it is as old as medicine itself. Psychosomatic medicine is an apt example. Emotional factors in disease have been recognized and more or less successfully coped with down through the centuries. Recently interest in this phase of medicine has been revived and progress can be anticipated.

A similar situation exists in geriatrics, a field which is now attracting wide attention. Writing on the subject, "Some Comments on the Early Literature of Geriatrics in America," in the August issue of the *New Orleans Medical and Surgical Journal*, Dr. William Dosite Postell observes that "one may obtain the impression that the study of geriatrics is of a comparatively recent origin. However, an examination of the literature reveals some very interesting facts in regard to this newest specialty.

"The art of caring for the aged is as old as the art of scientific medicine. Hippocrates made a number of observations on the aged. He noted that as a rule they complained less than the young, but from his keen insight into disease he concluded that such chronic ailments that do occur in the aging body rarely leave it. He summarized the diseases of old age as follows:

" 'Old men suffer from difficulty of breathing, catarrh accompanied by coughing, stranguary, difficult micturition, pains at the joints, kidney disease, dizziness, apoplexy, cachexia, pruritis of the whole body, sleeplessness, watery discharges from the bowels, eyes and nostrils, dullness of sight, cataract, hardness of hearing.' "

History also records others who were intrigued by this subject. There were Avicenna

(980-1037), who devoted one of his theses to the care of the aged; Roger Bacon (1214-94) who wrote a dissertation entitled "The Cure of Old Age and the Preservation of Youth"; and Luigi Cornaro, author of the first work on geriatrics to appear in America, "Sure and Certain Methods of Attaining a Long and Healthy Life." This latter work was written in the 16th century and published in America in 1793. Benjamin Rush, in 1805, devoted a chapter of a book on "Medical Inquiries and Observations" to "An Account of the State of the Body and Mind in Old Age; with Observations on Its Diseases." There were, of course, others down through the years, but it was not until the middle of the 19th century, according to Dr. Postell, that geriatrics became a scientific study.

"Gradually facts were being accumulated," he writes, "which when combined with the vast experiences of J. M. Charcot and rounded out with the lectures of Alfred Loomis gave to the study of the aged its high perspective." Experiences of these scientists were published in 1881. Since that time geriatrics has come a long way, yet it is still in its infancy. Much remains to be done if the degenerative diseases of middle and old age are to be stemmed.



*Doctor's
Guild
Organized*

In off-the-record conversations, physicians frequently express themselves in favor of unionization. Upon reflection they know that any such step is not only unworkable but undesirable. What would happen if doctors unionized has been the subject of serious discussion as well as humorous comment. One thing is certain, unionizing of medical practitioners would mean throwing all the traditions of medicine out of the window. Medicine would no longer be the great humanitarian profession. It would be a trade, which some argue the courts have declared it. However, this is not a fact, for the United States Supreme Court in the

Group Health case did not find that medicine was a trade per se, but a trade within the meaning of the Sherman Anti-Trust Act, which is quite a different matter. When medicine organizes along the lines of labor unions for the purpose of bargaining for more pay, shorter hours, and better working conditions, medicine as we have known it will have ceased to exist.

In view of this situation, it is not surprising that groups of doctors, having formed organizations for bargaining purposes, are reluctant to admit this fact. For example, there is the recently organized Railroad Physicians and Surgeons Guild in San Francisco. According to press reports, these physicians are members of the staff of the Southern Pacific Hospital in the Golden Gate City. A spokesman for the group denied reports that the prime purpose of the Guild is collective bargaining under the provisions of the Wagner Act. He is quoted as saying: "We sought to organize, so that we could coöperate with the Southern Pacific Company, the hospital, and its board of managers to give better service."

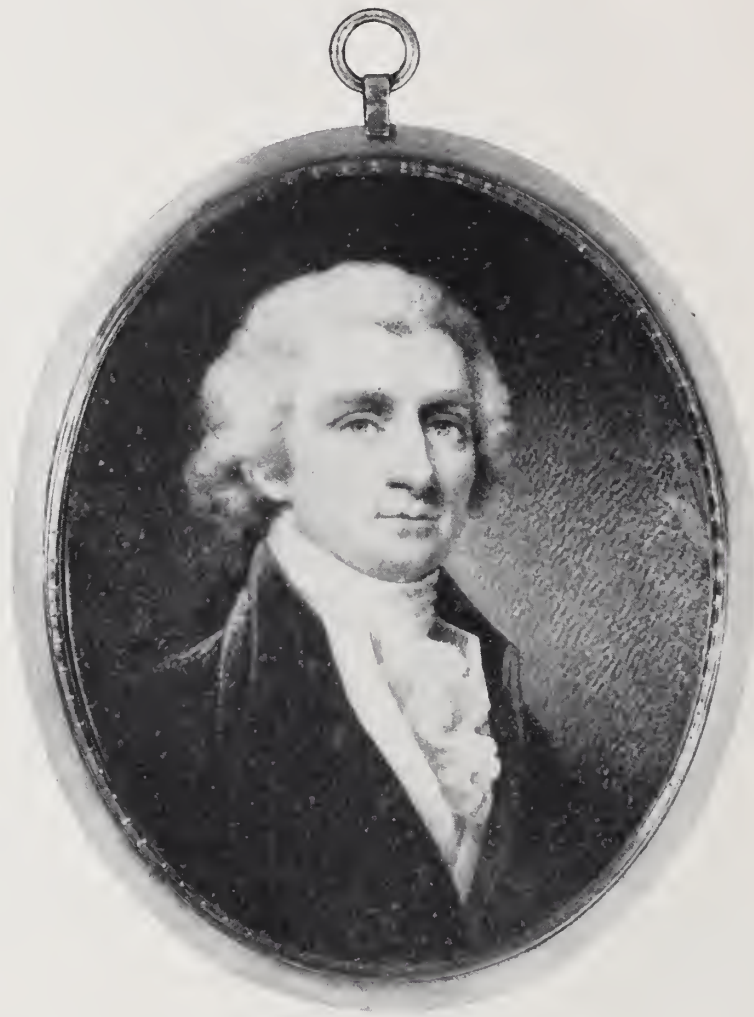
"In our purposes outlined for the guild, collective bargaining was not one of them. However, if the occasion arose, we presume collective bargaining would be entailed."

Dr. G. Dan Delprat, President of the San Francisco County Medical Society, defends the organization in the following words: "There appears to be nothing different in this guild in comparison to the various medical societies and organizations now in existence except that this is called a guild."

"As for collective bargaining. . . the San Francisco County Medical Society has done some collective bargaining."

Dr. Delprat may be right about the Guild although there is some doubt about that. Whatever the facts in this case may be, your Observer is certain that unionization of the medical profession along labor lines would be a fatal error.

Washington Physicians of Yesterday



WILLIAM THORNTON, M.D.

Dr. William Thornton, an important figure in early American history, became a member of the Medical Society of the District of Columbia the year it was granted its charter by Congress, 1819.

Dr. Thornton is perhaps best known as the architect of the Capitol building in Washington. However, he engaged in medical practice in the District and in the years 1820 and 1823 was Vice President of the Medical Society. But medicine, it appears, was not his primary interest. Following the completion of his medical studies in Edinburgh, Scotland, and in Paris, he traveled extensively throughout Europe. He married in 1790, returning to Washington from the Continent in 1793.

A writer of distinction, he published papers on many subjects including medicine, astronomy, philosophy, finance, government and art. He was associated with Fitch in the early experiments in running boats by steam, and patented a number of inventions. Placed in charge of patents at the time of the passage of the act of Congress creating the Patent Office in 1802, he retained this position until his death. In 1794, President Washington appointed him one of the three Commissioners of the District of Columbia. Lieutenant, then Captain in the War of 1812-14, he served his country with distinction.

Born on May 27, 1761, on Tortola Island, West Indies, Dr. Thornton died in Washington, March 27, 1828.

STRENGTHENING VENEREAL DISEASE CONTROL IN WASHINGTON

RAY H. EVERETT, LL.B.

Executive Secretary, Social Hygiene Society of the District of Columbia

Back in 1939, in an attempt to codify and simplify District health regulations dealing with communicable diseases, a compilation was adopted and published. Certain weaknesses in the new code soon became apparent, especially in relation to the control of syphilis and gonorrhea. In the spring of 1943 the Subcommittee on Public Health of the House Committee on the District of Columbia studied local conditions and recommended immediate revisions to strengthen the Health Officer's powers in this field. Attention again was called to the need for more adequate regulations by the Medical Society and the Social Hygiene Society early this year, as the gaps had not been remedied.

In September 1945 the House Subcommittee once more took cognizance of the problem and invited representatives of the Board of Commissioners, Health Department, Corporation Counsel's Office, U. S. Public Health Service, Army, Navy, Medical Society and Social Hygiene Society to testify at hearings on September 14 and 18. Major attention was devoted to a draft of a bill broadening the Health Officer's quarantine powers, but questions also were asked about other factors in the local venereal disease control problem, notably the matter of physicians reporting their cases to the Health Department, the question of additional needed legislation and the problem of prostitution and its repression. Some of the salient points of the hearing and its background are summarized in the following comments.

NEED FOR QUARANTINE POWERS

Sexual promiscuity and a positive dark field are a bad combination for public health. Similarly, with positive evidence of gonococcal activity, an individual may well be restrained from spreading the disease. Yet at present in the District of Columbia our legal restrictions are so weak that an actively infectious individual can virtually defy with impunity the Health Officer or private physician in so far as protecting the community is concerned—and get away with it. Hence both the physician and the health authorities, as well as the community, have vital stakes in the new legislation and regula-

tions designed to improve venereal disease control in the District.

Epidemiologically it is well established that syphilis and gonorrhea are spread via a series of small epidemics, in each of which one active carrier is the focal point. To do a real control job it is essential that these infectious foci be rendered noninfectious as expeditiously as possible. Modern rapid therapeutic procedures can accomplish this task if the infected persons are coöperative. But, when they refuse treatment, then surely the Health Officer should be granted quarantine powers which will authorize him to isolate such individuals and thereby safeguard the public. That is exactly what the newly drafted legislation seeks to accomplish.

Let's remember, in this connection, that even under the new legislation the Health Officer cannot compel anyone—no matter how great a menace he may be—to submit to treatment via needles, drugs or any other method that involves force. Where treatment is refused, his only resort is to quarantine. In essence he can deliver this ultimatum to the recalcitrant health hazard, "Either you accept the kind of scientific medical treatment that will make you no longer a danger to your fellow citizens or we will keep you isolated until you do!" No health department can function successfully in controlling communicable diseases unless it has this quarantine power well defined and readily available. Up to now, the D. C. Health Department's quarantine powers in venereal disease control have been neither sharply defined nor easily workable.

THE PROSTITUTION SITUATION

Some confusion exists in the minds of many regarding relationship of the control of venereal disease and the repression of prostitution. The former, it seems to us, is primarily the responsibility of health officers and physicians; the latter is a job for the police and courts. Syphilis and gonorrhea are medical problems, not legal offenses; prostitution is a legal problem regardless of whether or not the offender has a venereal infection. Effective co-operation should be extended by one department to

the other, but their fundamental objectives should not be obscured. Incidentally, in this connection, the District relies too largely on its "Vagrancy Law" to apprehend and try individuals accused of prostitution. Certainly a vagrant is not necessarily a prostitute and vice versa. Here, also, a comprehensive, clear-cut law is needed.

Fortunately, despite this rather weak law, Washington's commercialized prostitution has been kept to a low minimum by vigilant police efforts; but the District has been a veritable "paradise for pick-ups" in recent years, owing to the large number of visiting service men and to the host of government girl workers superimposed on the normal feminine population. The excess of venereal disease in the District from this source is not attributable to either health or police department laxity. It is largely a war hazard that may subside to a considerable extent as the war hysteria dies down.

REPORTING BY PHYSICIANS

District Commissioner Guy Mason was reported in the press as saying that "the local program would have functioned much better if local private doctors had coöperated with the Health Department, obeyed the present law and reported venereal cases they had treated." In our opinion such reporting, or its lack, had but little effect on the failure of existing regulations. Of what use is reporting if the Health Department lacks the power to act decisively when action might be indicated?

For many years, health officers have been divided into two groups on this reporting question. First, there are the "hardboiled" ones who believe in crack-down methods to compel reporting by the physician; second, there are those who are convinced that better results can be attained by education, by making the report forms simple and efficient, by aiding the physician in his own private-practice epidemiologic procedures, by furnishing drugs and laboratory help as an inducement to reporting, and by realizing that the stigma still attaching to venereal disease renders the patient unduly sensitive to getting his name on public records and makes the confidential relationship of physician and patient of even greater significance than is the case in other communicable diseases.

Reports are mainly useful for statistical purposes.

We would agree that more general reporting by physicians is desirable but, with the host of venereally infected persons who are undiscovered, the army of those who attempt self-treatment or resort to quacks, and the many who do not even know they are infected, the statistics of syphilis and gonorrhea are, as Nelson said, "too incomplete to permit of any sound conclusions, either as to their prevalence or trends." His program in Massachusetts, in many ways the most resultful in the United States, relied largely on educating and persuading the physician as to the values of reporting, both as a benefit to public health and as enlisting health department aid to the physician in holding his own patients.

Further pertinent comments of Nelson are as follows: "One group of health officers insists that the names and addresses of all the infected should be reported to the health department in order that epidemiologic investigations may be made by the health officer and his assistants, in the traditional manner. Their opponents argue that the success of any genitoinfectious disease control program hangs upon the guarantee of secrecy to the coöperative patient. They believe that neither the physician nor the infected will agree to the routine identification of patients to the health department, and that if any serious attempt is made to force this plan upon either, the whole program will be defeated by the rush for cover. Physicians will refuse to report and patients will give incorrect names or seek medical care from illegitimate sources.—If the mountain will not come to Mahomet, it may be worth Mahomet's while to make some effort to go to the mountain, instead of sulking in his tent over the mountain's obstinate refusal to 'coöperate.' "

Washington's Health Officer, during his decade in office, has pursued the policy of education, persuasion, and the provision of drugs and laboratory services, in his endeavors to secure routine reporting. No physician nor patient can be wronged by reports based on serial numbers, with the names submitted only in cases of recalcitrants who endanger public health by failure to continue treatment at least until noninfectivity is established. This type of coöperation will increase, we believe, as common interests and objectives are stressed and more complete understandings of mutual problems and viewpoints are reached.

(Continued on page 482)

Military Affairs

G. W. U. TO OFFER COURSES FOR RETURNING MEDICAL OFFICERS

The plans of the George Washington University School of Medicine for returning medical officers consist of three separate but integrated programs, designed to meet the needs of different groups of veterans.

For the fully qualified general practitioner or specialist, and for the younger physician who feels the need for a general review before starting further hospital training, a program of short "refresher" courses is planned, varying in length up to nine weeks. This nine weeks' course will allow review of all specialties in survey form. This instruction will be largely didactic but thoroughly illustrated and supplemented by "dry clinics" and conferences of different sorts.

This portion of the program will be closely integrated with the second part, in which there will be instruction in the hospital wards, dispensaries and laboratories. This phase of the program will vary from one to four weeks depending upon the field of study. It will be timed so that, for the specialist, it will follow immediately upon the didactic instruction in the first part of the program. The instruction will be completely practical and will be more advanced than that offered in the didactic program.

The third portion is a system of preceptor training, and will be designed primarily for those veterans who have completed or nearly completed their specialty training. It is felt that these men will need opportunity to renew their skills while being adequately supervised by competent physicians. Since it is likely that there will be too few hospital appointments to fill the needs of this large group, efforts

have been directed toward finding openings for these men in practice with established specialists.

The School of Medicine is canvassing all specialty groups using as a reference the available lists of specialists certified by the various boards. The response from these specialists has been quite heartening. It is hoped that by the time the canvass is completed about five hundred positions will have been opened up. Most of the specialists are willing to offer a livable salary, and frequently opportunity is afforded for building up a certain amount of practice by referral in the offices of the preceptor. Many of the preceptors have indicated that they would desire eventual partnership with "the right man," and others have suggested that they wish to retire as soon as the veteran becomes well established. Thus the veteran is offered a period of training plus opportunity in many instances for permanent establishment. Usually the opportunity will be contingent upon the veteran's own skill, aptitude and personality.

It is felt that this combination of plans will meet the needs of most of the medical officers for whom university-sponsored training is adapted. There will remain the need for expanded hospital facilities for resident training of the younger physicians. The clinical departments of the faculty are now adapting their facilities in this direction. It is hoped that all men needing and wanting advanced training can be accommodated.

Any further inquiry about this program can be directed to Dr. Thomas M. Peery, Secretary, Committee on Postwar Medicine, George Washington University School of Medicine, Washington, D. C.

SERVICE NOTES

Members of the Society who have been in service for the past several months but whose names have not been previously reported in the *ANNALS* are

Drs. Clayton B. Ethridge and Harvey H. Ammerman. Dr. Ethridge holds the commission of Lieutenant Commander and is serving in the Pacific

area; Dr. Ammerman, as First Lieutenant in the Army, is stationed at Camp Adair, Oregon.

Dedication ceremonies were held at the Madigan General Hospital, Tacoma, Washington, on August 20, 1945. This hospital, formerly known as the Fort Lewis Hospital, was named for Colonel Patrick S. Madigan, M.C., U.S.A., a native of the District of Columbia, who died May 8, 1944. Colonel Madigan was a graduate of Georgetown University School of Medicine.

Members of the Society are making a splendid service record as indicated by the number of promotions in rank which continue to come to the attention of the Society's office. Since last listed in the Annals they are:

John G. Ball, from First Lieutenant to Captain
John R. Cavanagh, from Lieutenant Commander to Commander

Worth B. Daniels, from Lieutenant Colonel to Colonel

Alfred A. J. Den, from Major to Lieutenant Colonel
Theodore C. C. Fong, from Lieutenant Colonel to Colonel

Elmer W. Fugitt, from Major to Lieutenant Colonel
Henry A. Grennan, from Captain to Major

J. Phelps Hand, from Captain to Major
Raymond T. Holden, from Commander to Captain
John Hugh Lyons, from Lieutenant Colonel to Colonel

Hector C. McKnew, from First Lieutenant to Captain

Raymond W. Murray, from Commander to Captain
Charles P. Ryland, from Lieutenant Commander to Commander

William A. Ryon, from Major to Lieutenant Colonel
Raymond L. Schwartz, from Captain to Major
Robert G. Taylor, from First Lieutenant to Captain
John W. Thomas, from Lieutenant to Lieutenant Commander

George Tolstoi, from Major to Lieutenant Colonel
Simon C. Weiner, from First Lieutenant to Captain

LETTERS FROM MEMBERS IN THE SERVICES

From Lt. Commander Gerald H. McAteer, c/o Fleet Post Office, San Francisco, Calif.:

Dear Ted: Today in the midst of our last air sea battle off Tokio we received word of the Japanese capitulation. I might add that all of the Japanese pilots were not in agreement as 22 Jap planes were splashed over our force long after the surrender was accepted.

It certainly was great news to the men aboard this cruiser and a most fitting climax to the sustained offensive of Admiral Halsey's Third Fleet against the Japanese homeland.

Our Third Fleet offensive started months ago at the Tokio plains and its purpose was the attrition of enemy air power. The offensive was maintained day and night until cease fire order was received August 15. Our air sweeps and strikes were interspersed with shore bombardments at various strategic points along the coast and obviously were a factor in helping lower their will to resist.

I approached the first shore bombardment of Japan with more than the usual apprehension. The target was Kamaschi, a city of forty thousand population producing steel in northern Honshu. I beheld the coast of Japan about ten a.m. and studied it through the glasses. Summer had apparently arrived and I couldn't help but admire the green mountainous terrain with the higher peaks blanketed with white clouds. My observations were interrupted by a terrific salvo from our big guns and those of the rest of our group. We closed to short range and proceeded to level the town. The industrial area was soon covered with dense smoke and fires spread over

a vast area. The destruction and havoc wrought by this type of offensive is only exceeded by the atomic bomb. Shore battery and antiaircraft fire were light and quickly eliminated. A small Jap destroyer singled us out for attack but was quickly destroyed by our secondary battery without inflicting damage. We retired after two hours to join the carriers while a number of kamikaze pilots harried us, only to be splashed when they came into range. Other bombardments followed but simulated our original pattern.

I believe the highlight of the whole offensive was, in addition to destroying almost three thousand enemy planes, the destruction of the remnants of the Japanese Navy which were hiding under camouflage in the Kure-Kobe area and the inland seaports. Three battleships, the Haruna, Nagato and Ise, six cruisers and two aircraft carriers, eight destroyers, fifteen submarines and many auxiliary vessels were sunk or beached by Third Fleet strikes between July 25 to 28.

The contrast of our fighting power and tactics this year and my cruise on the Hornet in 1942 was most striking in that all ships of this mighty task force are new, having joined the Fleet since the middle of 1942. This is a tribute to the productive capacity of our Nation.

Well, Ted, like all doctors in the service, I am glad to see the war's end, though there is still a great deal to be done in disarming Japan.

My solution to end all wars is simple and as follows: Force

(Continued on page 482)

News and Personals

Announcement has just been made that the **House of Delegates of the American Medical Association** will hold its annual meeting at the Palmer House in Chicago, December 3 to 6, 1945. The **Annual Conference of State Secretaries and Editors** will be held in Chicago in February 1946.

Elsewhere in this issue is an official announcement of the **Victory Meeting of the Southern Medical Association**, which will be held under the sponsorship of the Campbell-Kenton County Medical Society of Kentucky in Cincinnati, Ohio, November 12-15.

The **American College of Radiology** announces through its Executive Secretary, Mac F. Cahal, that the fiftieth anniversary of the discovery of X-ray will be celebrated on a national basis during the week of November 5 to 10. Discovery of the X-rays was made by the German physicist, Wilhelm Conrad Roentgen, on November 8, 1895, at the Physical Institute of the University of Wurzburg in Bavaria. During the anniversary celebration efforts will be made to acquaint parents with the important role of radiology in the early detection of disease in children.

Dr. Wallace Mason Yater has resigned from the faculty of **Georgetown University School of Medicine**. During his 21 years' association with Georgetown, Dr. Yater has served on the teaching staff as Instructor in Surgical Anatomy, Professor of Physical Diagnosis, Associate Professor of Medicine, and for the past 15 years as Professor of Medicine and Director of the Department of Medicine. Since 1930 he has helped to train approximately 45 Fellows in Medicine. Dr. Yater is also retiring as Head of the Department of Medicine, Georgetown University Hospital, and as Head of the Department of Medicine, Gallinger Municipal Hospital.

In addition to his professorial duties Dr. Yater has been active in the work of many national scientific organizations. He is serving as Governor of the American College of Physicians and is a member of the Committee on Credentials. He is

a diplomate of and adviser to the American Board of Internal Medicine, a former member of the Advisory Board of the Alumni Association of the Mayo Foundation, a member of the Committee on Medicine of the National Research Council and a member of its Subcommittee on Cardiovascular Diseases. He is also Past Chairman of the Section on Experimental Medicine and Therapeutics of the American Medical Association, Past Chairman of the Section for the Study of the Peripheral Circulation of the American Heart Association, and at present a Director of the latter Association. His membership in scientific organizations includes the American Society for Clinical Investigation and Sigma Xi.

Since his affiliation with the Medical Society of the District of Columbia in 1923 Dr. Yater has taken an active role in many of its activities. He is particularly well known as Editor of the **MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA**, which appointment he has held since its inception in 1932.

His textbook, "Fundamentals of Internal Medicine," first published in 1938, is used extensively in medical schools throughout the United States. A new edition of this textbook was completed by Dr. Yater in 1944. He is also the author of "Symptom Diagnosis" and approximately 150 published articles on medical subjects (mainly original contributions to medical science).

As a lecturer Dr. Yater has addressed medical meetings throughout the country. He delivered the Kober Memorial Lecture in 1938, and the Mayo Foundation Lecture in 1941.

Dr. Yater received his A.B. degree cum laude from George Washington University in 1917, and graduated in medicine from Georgetown University in 1921. After a few years in private practice in Washington, he enrolled at the Mayo Clinic as a Fellow in Medicine, receiving the degree of Master of Science in Medicine from the University of Minnesota in 1929.

Besides his teaching and research Dr. Yater is well known as a consultant and diagnostician.

The appointment of **Colonel Wallace H. Graham** of the Army Medical Corps to succeed Vice Admiral Ross T. McIntire as the President's personal physician was announced on September 13.

Colonel Graham was born in Highland, Kansas, in 1910. His family moved to Kansas City, Missouri, in 1918. There he received his early education. His premedical training was obtained at the University of Missouri. He graduated from Creighton University, Omaha, Nebraska in 1935 with the degree of Doctor of Medicine, and completed his training at Harvard University Medical School and the Massachusetts General Hospital.

Colonel Graham interned at the Kansas City General Hospital, following which he became a resident in pathology at the Cook County General Hospital in Chicago. Postgraduate training in surgery followed at the General Hospital of Wien, Austria, Varozi Hospital and University of Budapest, and the Royal College of Surgeons at Edinburgh.

At the time of the outbreak of World War II, Colonel Graham was associated with his father, Dr.

James W. Graham, Surgeon of the Missouri Pacific Railroad. Serving overseas, he was wounded shortly after the Normandy landing. He was invalided home but returned to the Continent before V-E Day. At Potsdam he met President Truman and shortly thereafter became the Presidential Surgeon.

In recognition of his outstanding military service, Colonel Graham received the Bronze Star and the Purple Heart. He participated in five major campaigns.

Plans for the health and hospital survey of the **Washington Metropolitan Health Council** are

moving forward rapidly, Dr. Herbert P. Ramsey, Chairman of the Council, announced September 14. Headquarters have been established at 1823 L Street, N. W., where two full-time administrative assistants have begun work. In charge of the office is Miss Mary F. Champlin, recently with the American Red Cross in the Pacific area. Assisting her is Mrs. Erminie Cross Lacey, formerly with the American Public Health Association.

The three surveyors, Drs. C. E. A. Winslow, Ira V. Hiscock and Claude W. Munger, were in Washington early in September to confer with officials of the Health Council on final arrangements for the survey.

In selecting the personnel of the Survey Committee of the Council, efforts were made to include persons from the six different political jurisdictions of the Metropolitan Area. The full committee is as follows: Vice Admiral Ross T. McIntire, Surgeon General of the Navy, *Chairman*; Dr. Ramsey, *Vice Chairman, ex officio*; Mr. Ramone S. Eaton of Alexandria, Director of the Eastern Division, American Red Cross; Mrs. Art Brown of Arlington



COLONEL WALLACE H. GRAHAM, M.C., U.S.A.

County, member of the Board of Directors of the Community War Fund; Colonel Waldron E. Leonard of Fairfax County, Director of the Community War Fund; Mrs. O'Neal Johnson of Montgomery County; Mrs. William Werber of Prince Georges County; Miss Gertrude H. Bowling, Executive Secretary, Instructive Visiting Nurse Society; Mr. George A. Garrett, President of Emergency Hospital; Dr. Vane M. Hoge of the U. S. Public Health Service; and Dr. Paul Cornely, Associate Professor of Health and Preventive Medicine, Howard University.

Among the list of advisers to the Survey Com-

mittee are Dr. Robert H. Riley, Maryland Commissioner of Health; Dr. I. C. Riggan, Virginia Commissioner of Health; Dr. George C. Ruhland, Health Officer, District of Columbia; Dr. John M. Byers, Health Officer, Prince Georges County; Dr. V. M. Ellicott, Health Officer, Montgomery County; Dr. Ralph G. Beachley, Health Officer, Arlington County; Dr. Nelson Podolnick, Health Officer, Fairfax County; and Dr. T. R. Shrop, Health Officer, Alexandria.

Numerous other names will be added as the survey progresses. Among them will be Dr. Harry F. Dowling and Mr. Theodore Wiprud, of the Medical Society, and Dr. Roy L. Sexton, Chairman of the Committee on Public Health of the Washington Board of Trade.

The survey is being financed with \$24,000 recently appropriated by the Board of Directors of the Community War Fund. Coöperation of 79 different agencies and hospitals in the Washington Metropolitan Area had been pledged up to September 14.

The Section on Neurology and Psychiatry met September 13 in the Society's Library. Dr. Walter Freeman read a paper on "The Pathological Findings in Amyotonia Congenita," which was prepared jointly with Dr. Dorothy V. Whipple, who discussed the paper. Election of new officers for 1945-46 ensued. They are as follows:

Dr. Robert T. Morse, *Chairman*; Dr. Isadore Rodis, *Vice Chairman*; Dr. Vasilios S. Lambros, *Secretary-Treasurer*.

Dr. Roy Graham Hoskins, the Salmon Memorial Lecturer for 1945, has selected "The Biology of Schizophrenia" as the title for the lecture series which is sponsored annually by the Salmon Committee on Psychiatry and Mental Hygiene of the New York Academy of Medicine. The lectures will be given on three successive Friday evenings, November 2, 9 and 16, at 8:30 p.m. at 2 East 103rd Street.

Dr. Hoskins has for some eighteen years devoted much of his time to investigation of endocrine disturbances in mental disease, and is internationally known for his contributions to both the neuro-endocrinological and psychological fields. He is a member of the faculty of Harvard Medical School as Research Associate in Physiology and is Director of both the Memorial Foundation for Neuro-En-

CALENDAR OF MEETINGS

September 6	Grievance Committee
September 7	Program Committee
	Committee on Service Physicians
September 10	Chairmen and Vice Chairmen of all Committees
September 13	Section on Neurology and Psychiatry
September 20	Subcommittee on Prepaid Medicine
September 21	Committee on Industrial Medicine
September 24	Executive Board
September 26	Committee on Medical Care

docrine Research, Boston, and the Worcester State Hospital, Worcester, Mass. At present he is serving as a member of the Advisory Committee for Research and Education to the Commissioner of Mental Health, Commonwealth of Massachusetts, a member of the Committee on Endocrinology, National Research Council, and Secretary, Worcester Foundation for Experimental Biology.

Special exercises marked the beginning of the 122nd academic session of **George Washington University School of Medicine**, September 17. Guest speaker for the occasion was Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, who chose for the title of his address, "Health in the Postwar Period." Dr. Cloyd Heck Marvin, President of the University, spoke briefly.

Following the program Dr. Walter A. Bloedorn, Dean of the School of Medicine, was host to the speaker, faculty members and other invited guests at a luncheon at the Mayflower Hotel. Among those present were the Surgeons General of the Army and Navy and a number of leaders in the field of public health.

The District of Columbia Pharmaceutical Association has promised to assist **Dr. John H. Trinder**, representing the Medical Society of the District of Columbia, in an effort to obtain samples of medicines and unused medical instruments to be sent to the people of the Philippine Islands. Local drug-stores have agreed to act as collection centers for these supplies which are urgently needed.

Among the medical officers who have stopped in at the Society's offices during September upon their return to this country are **Lt. Colonel Clayton H. Hixson, Major Paul Wilner, Captains Brooks G. Brown, Jr., Sydney Leventhal, Robert G. Taylor and Maurice van Kinsbergen**, all members of the Army Medical Corps. Most of these physicians have spent more than two years overseas in the European area. Captain van Kinsbergen, however, served in the Pacific area until about a year ago. Since then he has been stationed at Clearwater, Florida.

Credit should have been given to **Dr. Leslie H. French** for an excellent picture of Sir Alexander Fleming which appeared in the August issue of *MEDICAL ANNALS*. Photography is Dr. French's hobby and his pictures of Sir Alexander demonstrate the skill he has acquired in his avocation.

Dr. Winfred Overholser spoke on "Psychiatry, What It Is and What It Is Not," September 4, before members and guests of the Washington Chapter of Special Libraries Association.

The Business Office of Surgery, Gynecology and Obstetrics has informed the Medical Society that they are lacking certain current and back issues of their publication for which they are willing to make liberal payment provided the text matter is complete and not mutilated or defaced in any way. They are offering \$1.00 each for the following back issues: 1905—July—November, incl.; 1906—January, March, July—November, incl.; 1907—January—April, incl., June—August, incl., October; 1908—January—December, incl.; 1909—June, December; 1910—May.

For the following current issues 75 cents each is offered: 1943—March; 1944—January—April, incl., August, September; 1945—January—March, incl., May, June.

The journals should be returned by second class mail or parcel post, whichever rate is lower, to the Business Office of Surgery, Gynecology and Obstetrics, 54 East Erie Street, Chicago 11, Ill. The sender will be reimbursed for the postage and payment made immediately upon receipt of journals.

MEETINGS

Wednesday, November 14

"Toxicity and Potential Dangers of 'DDT' to Humans and Warm-Blooded Animals," **PAUL A. NEAL, M. D.**, Medical Director and Chief of Industrial Hygiene Research Laboratory, National Institute of Health.

Wednesday, November 28

"Treatment of Pneumonia," **RUSSELL L. CECIL, M.D., Sc.D.**, F.A.C.P., Professor of Clinical Medicine, Cornell University Medical College, New York City.

CORRESPONDENCE

WASHINGTON, D. C., September 18, 1945

MR. THEODORE WIPRUD, SECRETARY

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

1718 M STREET, N.W.

WASHINGTON, D. C.

DEAR MR. WIPRUD:

I am attaching a copy of a letter received from our Eastern Area office, which is self-explanatory. Would it be possible for your office to be of assistance in filling this request? Any aid you could give would be greatly appreciated.

Sincerely,

NAT C. WILSON

Manager, District of Columbia Chapter,
American Red Cross

September 17, 1945

MR. NAT C. WILSON, MANAGER

DISTRICT OF COLUMBIA CHAPTER

AMERICAN RED CROSS

1730 E STREET, N.W.

WASHINGTON, D. C.

DEAR MR. WILSON:

As part of our assistance to Red Cross in the Philippines, Insular and Foreign operations at National Headquarters is gathering four collections of American medical journals, which will be turned over to the Red Cross in the Philippines for distribution to hospitals and libraries.

The first collection is now complete except for the following numbers of the *American Journal of the Medical Sciences*: 1944 volume 207 no. 5, volume 208 nos. 1-6. We are anxious to obtain these issues as soon as possible so that shipment will not be delayed. Would it be possible for you to make an appeal to your membership for a donation of these issues needed. In addition we should be very glad to have three copies each of the *American Journal of the Medical Sciences* for the following years: 1942, volumes 203, 204; 1944, volumes 207, 208 and two copies each of the issues for 1943, volumes 205 and 206.

If you are able to supply us with these publications, we will be happy to forward them to the proper service in National Headquarters.

Very truly yours,

V. A. PHILLIPS

*Regional Director, Eastern Area,
American Red Cross*

WASHINGTON, D. C., September 19, 1945

MR. THEODORE WIPRUD, SECRETARY
DISTRICT OF COLUMBIA MEDICAL SOCIETY
1718 M STREET, N.W.
WASHINGTON, D. C.

DEAR MR. WIPRUD:

We are happy to acknowledge receipt of 677 periodical contributions for our use by the members of the District of Columbia Medical Society.

At a time when the Army Medical Library is expanding its activities through the international exchange of duplicates, these recent issues will be of great benefit to us in trading with institutions all over the world.

Our holdings of foreign publications are showing a decided upswing, and such welcome gifts contribute in no small measure to the development of our acquisition program.

Please thank the individual members for their generosity.

Very sincerely yours,

WYLLIS E. WRIGHT

The Librarian, Army Medical Library

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review. After the reviews have been published the books will be placed in the New Book Section in the Medical Society's Library. There they may be examined at leisure but cannot be removed from the building.

The Male Hormone. PAUL DE KRUIF. Price, \$2.50. Pp. 243. New York: Harcourt, 1945.

Diseases of the Breast, 2nd ed. CHARLES F. GESCHICKTER, M.A., M.D., Lt. Comdr., Medical Corps, U. S. Naval Reserve; Director of The Francis P. Garvan Cancer Research Laboratory; Pathologist, St. Agnes Hospital, Baltimore, with a Special Section on Treatment in Collaboration with Murray M. Copeland, A.B., M.D., F.A.C.S., Instructor in Surgery, Johns Hopkins Medical School; Visiting Surgeon and Assistant Oncologist, Uni-

versity Hospital, University of Maryland Medical School; Visiting Oncologist, Baltimore City Hospitals. Price, \$12.00. Pp. 826, with 593 illustrations. Philadelphia: Lippincott, 1945.

Manual for Coding Causes of Illness According to a Diagnosis Code for Tabulating Morbidity Statistics. Prepared by Direction of the Surgeon General in the Division of Public Health Methods, U. S. Public Health Service, with the coöperation and assistance of the Division of Vital Statistics, U. S. Bureau of the Census, the Johns Hopkins Hospital and School of Hygiene and Public Health and the Mayo Clinic. Pp. 489. Miscellaneous Publication No. 32. Washington, D. C.: Government Printing Office, 1944.

MORRIS I. BIERMAN, B.S., M.D.

(1893-1945)

Lt. Comdr. Morris I. Bierman, well known radiologist, died suddenly at his home, 1401 Floral Street, N.W., a few hours after his arrival home from a tour of duty in the Pacific.

Dr. Bierman was born in Minneapolis, Minnesota, December 18, 1893. He received the degree of Bachelor of Science in Medicine from George Washington University, and the degrees of Bachelor of Medicine and Doctor of Medicine from the University of Minnesota, the latter in 1920. In 1921 he began practicing medicine in the District of Columbia. For a number of years he had limited his practice to radiology, maintaining his office at 1801 Eye Street, N.W. Before entering the service he was a member of the staffs of Emergency and Providence Hospitals.

In July 1942 Dr. Bierman entered the Medical Corps of the U. S. Naval Reserve with the rank of Lieutenant Commander. He was on active duty in the Atlantic early in the war, then for a short time was stationed at the Naval Hospital at Bainbridge, Maryland. For the past 18 months he had been on duty aboard an LST in the Pacific area, and had just returned to his home in Washington when death occurred. En route home he had met one of his sons, Daniel, a seaman in the Navy, in San Diego.

Dr. Bierman had been an Active Member of the Medical Society of the District of Columbia

since 1924. He was a Fellow of the American Medical Association and a member of the Radiological Society of North America.

Surviving him, in addition to his son Daniel, are his wife, Mrs. Elizabeth Bierman, another son, Noah, a daughter, Mrs. Josephine Simons, all of Washington, and his mother, Mrs. Ida Bierman, of Minneapolis, Minn.

Jaundice in the Army—Parr

(Continued from page 449)

disease is considered. Encouragement is given to the view that the "reaction pattern" of an individual, made up possibly of many factors in addition to the possession of serum or cellular immunity, merits more study than it has received.

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3. BAYNE-JONES, S., AND WALKER, D. W.: Outbreak of jaundice in United States Army in 1942, to be published.
4. TURNER, R. H., AND OTHERS: Some clinical studies of acute hepatitis occurring in soldiers after inoculation with yellow fever vaccine, with especial consideration of severe attacks. *Ann. Int. Med.*, 1944, **20**, 193.
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6. LUCKE, B.: Structure of liver after recovery from epidemic hepatitis. *Ibid.*, 1944, **20**, 595.
7. GRIFFIN, A. M.: Personal communication.
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Venereal Disease Control—Everett

(Continued from page 474)

OTHER NEEDED LEGISLATION

At present thirty-six states throughout the Nation have premarital and prenatal health laws. In some of these commonwealths, congenital syphilis has been almost eliminated. As most readers know, these two laws provide for routine blood testing of (a) prospective marital partners and (b) expectant

mothers. They have proved useful adjuncts to the venereal disease control programs; their provisions are simple and present no grave administrative difficulties. For those reasons they have been officially included in standard venereal disease control procedures recommended by the American Public Health Association and the United States Public Health Service. Their inclusion in the District of Columbia public health armamentarium seems worthy of scientific advocacy.

CONCLUSION

Some who have read this far may say, "Numerous other factors enter into all of the problems outlined. Why was this point omitted? or this?" We can reply merely that another hundred thousand words readily could be used, without adequate coverage being attained even then. Fortunately neither time, space, nor inclination will permit their use!

Letters from Members in Services

(Continued from page 476)

all war mongers to subsist on dehydrated potatoes, powdered eggs and spam for an indefinite period.

The Navy is not releasing doctors as yet but I look forward to returning to civilian life and practice and giving these over-stimulated adrenals a rest.

My best regards to all.

From Commander Charles P. Ryland, *U. S. Fleet Post Office, San Francisco, Calif.*:

Dear Ted: Just a note to let you know that I have arrived aboard my ship and will be looking forward to getting the *Annals* and your letters at the above address.

You will note that I have been promoted since I wrote to you last.

From Lt. Commander E. Stuart Lyddane, *U. S. Fleet Post Office, New York, N. Y.*:

Dear Mr. Wiprud: Have received with pleasure for the past 16 months all your nice letters from D. C. They are really just like reading a page from home. While I know that 16 months is not a long time in comparison to the time spent overseas by many others, yet for me who always was a home boy it is like a century. As you know, I was raised in the section of D. C. (Georgetown) where I practiced for 12 years, and while not being very active in the Society, due to the old gag of work, I was always proud, however, to be one of its members. And again, not being much of a letter writer and a great "putter off," I have delayed time and again to answer and thank you for permitting me to see and read these nice juicy bits of news from home.

As I expect to be back in the States in the near future, I feel duty bound to tell you how much I have appreciated and enjoyed your letters during my tour of duty in Italy, France and North Africa.

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NUMBER 11

THE ROLE OF THE SMALL VESSELS AND NERVES OF THE HEART IN HEART FAILURE, CORONARY ARTERY THROMBOSIS AND CARDIAC PAIN*†

JOSEPH THOMAS ROBERTS, M.D., PH.D.

Chief Medical Officer, Department of Medicine, Gallinger Municipal Hospital; Adjunct Clinical Professor of Medicine, George Washington University and Georgetown University Schools of Medicine

THE significance of diseases of the larger coronary arteries has become recognized in recent decades as a very important factor in the cause of cardiac pain and heart failure. It has also become recognized to some extent

that impairment of the blood flow to the heart as a result of decreased blood volume, anemia or shock may contribute to heart failure and cause cardiac pain especially in patients who have some preëxisting stenosis of the coronary arteries. On the other hand, very little attention has been given to the role of the smaller coronary vessels in studies of the mechanism of heart failure and cardiac pain. The purpose of the present communication is to bring together several original investigations which seem to indicate that the smaller blood vessels of the heart play a very significant role in the failing heart and in the patient who has cardiac pain.

According to an analysis of the causes of heart failure in 1941,¹ it appears that the actual cause of heart failure is impairment of the nourishment of, or of removal of metabolic products from, the individual myocardial fibers. This may be affected by a large variety of

* This work was conducted in the Department of Medicine, Western Reserve University School of Medicine, and Lakeside Hospital, Cleveland, Ohio; in the Departments of Medicine, Anatomy, Pediatrics, and Experimental Research at the University of Texas School of Medicine, Galveston, Texas; in the Department of Anatomy, Tulane School of Medicine, New Orleans, Louisiana; and in the three Washington institutions.

The studies were financed by the Rees Fellowship and Commonwealth Fund at Western Reserve University, by appropriations of the Texas State Legislature, and by grants from Roche-Organon, Inc., Bilhuber-Knoll Company, and Burroughs-Wellcome and Company (U. S. A.), Inc. The work described in this paper, particularly the section on nourishment of the cardiac nerves, was done in part under a contract, recommended by the Committee on Medical Research, between the Office of Scientific Research and Development and the University of Texas.

† The Davidson Lecture, presented before the Society, October 17, 1945.

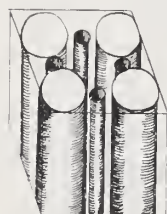
mechanisms, in turn due to noncardiac as well as cardiac causes. The variety of etiologic and other classifications of heart disease are of little fundamental significance in explaining heart failure except in so far as they affect the integrity of the individual muscle fibers.

The lesion which impairs the nutrition of the individual muscle fiber may be: (1) partial or complete obstruction at the mouth of one of

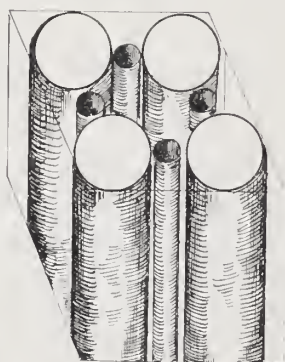
the nutrition of the muscle cells. This decrease in capillary blood supply of the myocardium may be (a) actual, as a result of spasm, inflammation, rupture, sclerosis, embolism, angulation or thrombosis of the capillaries or of the coronary arteries supplying them, or (b) relative, as a result of either increased need for blood supply from increased activity of the heart or because of a decrease in the concentration of the capillaries. Actual disease of these capillaries is likely to occur in a great variety of conditions, for example, rickettsial infections, nephritis, bacteremia, rheumatic fever, etc.

MUSCLE FIBERS AND CAPILLARIES

NORMAL ADULT



HYPERTROPHY



NORMAL INFANT



FIG. 1. Diagrams of the relationship of muscle fibers and capillaries in the normal adult human heart, in the hypertrophied adult human heart, and in the heart of the newly born human infant, showing changes in the capillary surface area per unit volume of muscle fiber.

the major coronary arteries, (2) stenosis or occlusion of a major coronary artery or one of its important branches, (3) obliteration of some of the smaller unnamed branches of the coronary arteries, (4) valvular or other lesions which prevent proper flow of blood through the heart and so impair the flow of blood in these important coronary vessels, and, in addition, (5) decrease in the amount of blood flowing through the capillaries of the myocardium which may impair

CAPILLARIES IN HYPERTROPHIED HEARTS

After injecting the capillary bed of 76 human hearts, following revival by perfusion, my co-workers and I^{2,3} measured the average diameter of the muscle fibers and counted the number of capillaries and fibers per square millimeter. The capillaries run parallel to the muscle fibers, and it was apparent that in hypertrophied hearts the capillaries were less numerous in a given area than they were in hearts of normal size (fig. 1).

In the hearts of 26 normal adults there was 1 capillary for each fiber. The average fiber diameter was 13.9 microns, and there were 3,342 capillaries per square millimeter.

In the hearts of newly born infants there was 1 capillary to supply 6 of the small fibers, the average fiber diameter was 6.4 microns, and there were 3,365 capillaries per square millimeter.

In the hearts of 40 adults with hypertrophied hearts as a result of heart disease, there was still approximately 1 capillary for each fiber but the average diameter of the muscle fibers had increased to about 20 microns, and the average number of capillaries per square millimeter fell to 2,483.

By analysis of these measurements and counts, it was shown that the capillary blood supply of the heart per unit area becomes diminished in proportion to the degree of cardiac hyper-

trophy, for the capillaries do not multiply during hypertrophy as they do during normal growth. From these data it was possible to calculate the area of capillary surface available for diffusion of oxygen and metabolites to and from the unit volume of contractile muscle tissue. Assuming the average diameter of the capillaries to be uniformly 7.5 microns, and using the formulas for calculating surface area and volume of cylinders, it was found that the capillary surface area per cubic centimeter of muscle fiber fell from an average normal value of 1,184 square centimeters to an average value of 623 square centimeters for the entire group of hypertrophied hearts, or to as low as 400 square centimeters for a heart weighing 1,050 grams.

Another way of expressing the results of these measurements is to say that the distance from the wall of the capillary to the edge of the cylinder of tissue around it and supplied by it is increased in proportion to the degree of cardiac hypertrophy.

When the heart weight in each case was compared graphically with the capillary surface area per cubic centimeter of muscle fiber tissue, the cases were found to be arranged in 2 groups. In the cases with normal hearts, there was a rather wide range, whereas in the cases with hypertrophied hearts, there was a close negative straight-line correlation between the heart weight and the capillary surface area per cubic centimeter of muscle. This was interpreted as meaning that in normal hearts there is a rather wide range of available capillary surface area with a critical point below which hypertrophy of the heart was found to occur.

"Loss of cardiac reserve" is used loosely by clinicians and physiologists to refer to the inability of a failing heart to respond to the demands upon it. It seems plausible to conclude that a decrease in the capillary surface area available for nourishing a given volume of muscle fiber tissue is the important mechanism by which cardiac reserve is decreased in hypertrophied hearts.

Several investigations of the chemical changes in cardiac hypertrophy have been made. These studies have indicated that in cardiac hypertrophy and failure there may be a relative or actual depletion of creatine and various phosphorus compounds. We¹ found that there was actual depletion of phospho-creatine in the hearts of dogs having chronic experimental valvular disease with hypertrophy and failure.

Myoglobin or muscle hemoglobin is a substance which was found to be extremely attractive to oxygen and repellent to carbon dioxide as compared with blood hemoglobin. This suggested to my co-workers and me the probability that myoglobin may exert an important role in attracting oxygen from blood to the muscle cells and repelling carbon dioxide into the blood. Studies begun with Price and Wearn² have indicated a difference in the concentration of myoglobin during normal growth and hypertrophy. It may be that changes in the concentration of myoglobin in the cardiac muscle fibers is a partial compensation for the decreased blood supply in hypertrophied cardiac muscle, and that when this compensation is exceeded, cellular hypoxia and cardiac failure ensue. Further studies are necessary before therapeutic use of this hypothesis can be made.

PRACTICAL APPLICATION

These observations have led me to the belief that hypertrophy of the heart is a harmful mechanism rather than the beneficial response to excessive demands which one commonly ascribes to increase in size of any muscle. From a practical standpoint, at any rate, I have found it wise to consider hypertrophy as an evidence that heart failure has occurred and that it will become worse.

It has been my practice for several years to recommend treatment for heart failure in cases having significant cardiac enlargement even in the absence of the usual criteria for pulmonary congestion or increased systemic venous pressure. Limitation of activity, reduction in

weight, and the use of oxygen, diuretics, sedation, vitamins and vasodilators should be recommended to such patients when they are fortunate enough to have their cardiac enlargement detected before clinically obvious heart failure has developed. Digitalis is one of the most helpful drugs in the treatment of congestive heart failure, and it was suggested many years ago by Christian⁵ that it should be given to all patients with cardiac hypertrophy.

This concept that hypertrophy represents heart failure may be readily interpreted as favoring the routine, careful use of digitalis in cases having cardiac hypertrophy.

Extending this concept one step further and using a therapeutic trend developing with other drugs leads me to the belief that any patient having cardiac failure with significant enlargement of the heart should have whatever benefit digitalis can give as soon as possible. In line with this belief, I have digitalized many patients immediately by the use of single doses of one of the potent crystallized derivatives, such as Digoxin, Digilanid, Cedilanid or Digitoxin. In 100 cases so treated, I have seen no indication of significant toxic effects from such use of the drug. It seems logical to believe that every patient needing digitalis needs its effect as soon as it can be obtained with safety or without toxicity, rather than waiting the 7 or 10 days required by the usual slow method of digitalization. Even very brief periods of transitory ischemia may produce irreversible changes in the myocardium demonstrable histologically and chemically as shown by Blumgart and others.⁶ For this reason alone it seems to me that there can be no unanswerable objection to digitalizing a patient as rapidly as can be done safely with the preparations available.

In my own opinion, different though it may be from that of many experienced internists, immediate digitalization by a single dose of one of the fine glycosides now available is the method of choice for every patient needing the

effect of digitalis. There is quite properly much fear and conservatism on the part of most physicians in first trying this method. However, there is an evident trend in the direction of more common use of the glycosides in preference to the whole leaf drug. My prediction is that within a very few years this method of using digitalis will replace the present common practice of giving the whole leaf drug for a week to get digitalization, just as the tincture was replaced by digitalis folia a few decades ago.

Good practice, of course, requires knowledge of the proper dosages and alternative methods of using these glycosides. The methods of using these preparations which have seemed best to me are given in table 1.

Still another application of this concept has been used in the treatment of patients having organic heart disease with hypertrophy but without obvious congestive failure when they face an abrupt increased strain upon the cardiac reserve, such as parturition, surgical operation, forcing of fluids as in uremia, or increase in activity. It has been my impression that patients with cardiac hypertrophy are prevented from developing congestive heart failure during labor and operation by the previous administration of Digoxin or a similar preparation to obtain immediate digitalization.

An important experimental confirmation of this practice has recently been published by Erickson and Fahr,⁷ who found that patients having organic heart disease without heart failure had greater cardiac efficiency when digitalized with Lanatoside C than when they were not digitalized.

NOURISHMENT OF CARDIAC NERVES

The anatomy of the nerves of the myocardium has been a subject of disagreement among various groups of workers. However, according to Nonidez,⁸ his work and that of Stöhr⁹ and Seto,¹⁰ indicate that the vagus and sympathetic nerves form a plexiform or syncytial arrange-

TABLE 1
The Use of Cardiac Glycosides
(For Patients with Congestive, Noncongestive or Imminent Heart Failure)
(A) Oral Digitalization

DRUG	TABLET SIZE	DIGITALIZATION DOSE	MAINTENANCE DOSE
Digoxin (Burroughs Wellcome)	0.25 mg.	1.5 mg. and 0.25 mg. ea. 6 hours if ventricular rate is above 80; 1.0 mg. if weight is below 100 lbs.	0.5 mg. daily; or 0.25 mg. daily if rate is below 60.
Cedilanid (Sandoz)	0.5 mg.	5 to 7.5 mg.	0.5 mg. daily; 1.0 or 1.5 mg. daily if pulse is above 100
Digitaline Nativelle (Varick)	0.1 mg. (pink) 0.2 mg. (white)	1.2 mg.	0.2 mg.; may vary from 0.1 to 0.3 mg.
Digitoxin (Squibb)	0.1 mg.	1.2 mg. to 1.5 mg.	0.1 mg.; 0.2 mg. if pulse is above 100
Purodigin (Wyeth)	0.2 mg. (scored)	1.2 mg.	0.2 mg.; 0.1 mg. if pulse is below 60
Digilanid (Sandoz)	0.3 mg.	3.3 mg.	0.3 mg.

Note: Patients with ordinary or minor degrees of failure may be treated orally according to the above schedule. The "digitalization dose" may be given in 1 dose, or divided into 2, 3 or more fractions during the first day. The "average maintenance dose" may be used usually; if toxicity develops or the patient is smaller than 100 lbs., a smaller dose may be adequate, and if the rapid rate is not controlled a larger dose may be needed.

(B) Parenteral Digitalization

DRUG	AMPULE SIZE	DIGITALIZATION DOSE	ROUTE
Digoxin (Burroughs Wellcome)	0.5 mg. = 1 c.c.	1.5 mg.; 1.0 mg. if weight is below 100 lbs.	Each ampule diluted in 10 c.c. of saline, I. V. only
Cedilanid (Sandoz)	0.4 mg. = 2 c.c., 0.8 mg. = 4 c.c.	1.6 mg.	I. V. or I. M.
Digitaline Nativelle (Varick)	0.2 mg. = 1 c.c., 0.4 mg. = 2 c.c.	1.2 mg.	I. V. only
Digilanid (Sandoz)	0.4 mg. = 2 c.c., 0.8 mg. = 4 c.c.	0.8 mg. 0.8 mg.	I. M. I. V. slowly

Note: Patients with serious degrees of failure or with great distress from failure may be treated parenterally according to the above schedule. The "digitalizing dose" may be given in 1 dose or divided into 2 or 3 fractions during the first day. The maintenance dose should then be given orally on following days. This route may be used also for patients who cannot be treated orally for any reason.

ment, applied against the surface of the individual muscle fibers or lying freely in the spaces between the fibers. Assuming this arrangement to be the correct one, it can be shown diagrammatically that the blood supply and nourishment of the terminal nerve fibers in the myocardium need not be impaired by the pushing apart of the capillaries which accompanies the hypertrophy of the individual cardiac muscle fibers (fig. 2).

In other words, the distance from the capillary wall to the nerve fiber would not be increased as is the distance from the capillary wall to the nucleus of the muscle fiber in cardiac hypertrophy.

It has been a common observation by myself and many other clinicians with whom this matter has been discussed that patients with great cardiac hypertrophy and failure may be notably free from cardiac pain in the absence of major coronary artery occlusion. I believe that this curious observation may be explained best by this new concept that the blood supply of the terminal nerve fibers in the myocardium is not diminished as a result of the hypertrophy of the muscle fibers.

To determine whether the blood supply of a peripheral nerve is important in the function of the nerve I^{11,12} have devised several experiments on dogs and human beings in the past 12 years. I demonstrated by injection of the major vessels of an extremity that the blood supply of the peripheral nerves is very abundant. Each nerve has its own blood supply derived from vessels running nearby. From the segmental nutrient arteries a vascular plexus is formed in the perineurium supplying each nerve and from this plexus on the surface a plexus of capillaries runs longitudinally in the nerve between the individual axones. A very small blood vessel accompanies even the tiny single-axone terminal nerves in the skin, as we¹³ found by the use of a transparent chamber grafted into the skin of a rat's back.

When the blood supply of a segment of peripheral nerve was impaired (by ligating the nutrient arteries, by gently stripping away the perineurium with its blood vessels, by crushing or stretching the nerve, by placing bands around the nerve or a tourniquet around the limb, or by producing embolism due to injection of air, graphite or lycopodium spores into the nutrient artery) I¹² was able to demon-

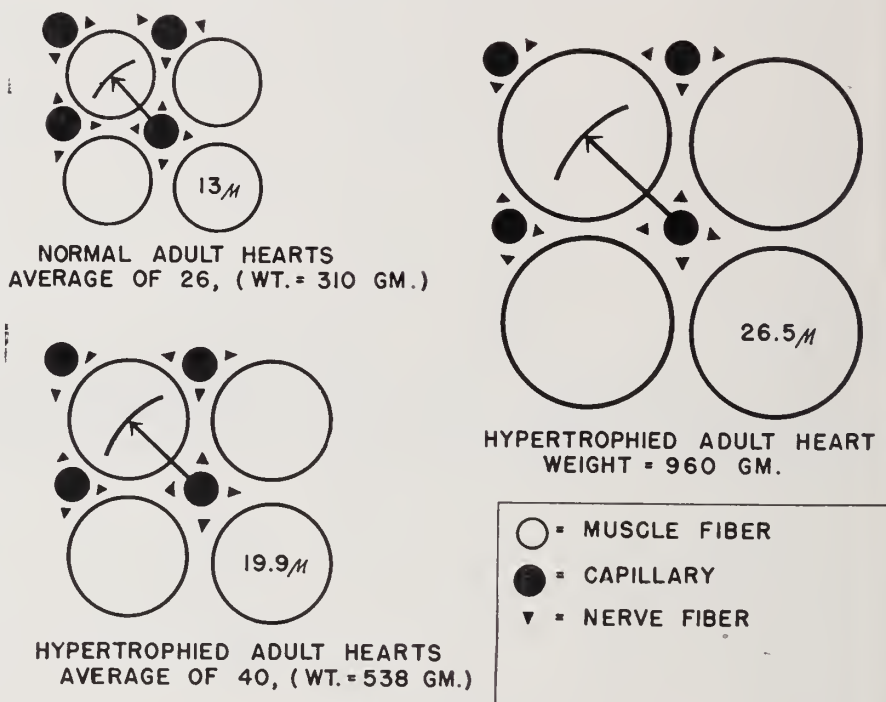


FIG. 2. Diagrams of the relationship of myocardial fibers, capillaries, and nerves in normal and hypertrophied human hearts.

strate by injection of dye in 23 dogs that the affected segment of the nerve became ischemic, and that the nerve lost its ability to conduct electric stimuli. In 26 dogs chronic ischemia was produced surgically by similar procedures. These animals developed paralysis, loss of tone and atrophy of the muscles, abnormal reflexes, trophic ulcers and degeneration of nerve fibers. In operations made as controls in which the nerve was exposed in the same manner but without injury to the vasa nervorum, no such abnormalities were observed.

In 10 human subjects in whom a limb was

amputated because of vascular disease, I¹⁴ have injected the major artery of the limb and dissected carefully the peripheral nerves. In each case I found closer correlation between the neurologic studies made before amputation and the level of ischemia of the nerve than between the functional observations and ischemia of other tissues. These patients had impairment of the blood supply to the peripheral nerve by arterial occlusion associated with diabetic or other neuropathy, or due to embolism resulting from subacute bacterial endocarditis or mural ventricular thrombosis, or by phlebothrombosis. In these cases severe pain accompanying the onset of the condition was soon followed by disappearance of the pain, which I believe is explained by assuming that at first there was partial ischemia of the nerve acting as a stimulus to pain, followed by complete neural ischemia which resulted in the inability of the nerve to conduct stimuli.

Combining this work on the blood supply of peripheral nerves with the previous studies on the capillary per fiber ratios in human hearts, an hypothesis may be devised that the nerve fibers in the myocardium do not get painful stimuli from the ischemia of cardiac hypertrophy because the nerve fibers are still as close to their capillary blood supply as in the normal-sized heart.

Other problems aided by this study of the blood supply of nerves are the difficult ones of explaining (1) why some patients have no pain after coronary artery occlusion with myocardial infarction and (2) why there is frequently disappearance of angina pectoris after coronary artery occlusion with myocardial infarction. In such a condition one could hypothecate that if the blood supply of the nerves in the segment supplied by the stenosed coronary artery was only partly diminished, the relative ischemia of the nerve would result in pain but that if the blood supply of the nerve was completely destroyed the nerve would no longer be able to conduct impulses initiated by painful

stimuli. In other words, the presence or absence of pain in coronary artery thrombosis would depend upon the degree of depletion of the blood supply to the nerves in the infarcted area. Similarly, during the months or years when a person has angina pectoris the blood supply to the nerves in the myocardium may be diminished by narrowing of the coronary arteries, but there is enough blood supply to the nerves so that they can conduct impulses from painful stimuli. Later, as so often occurs, thrombosis in a major coronary artery (and in its anastomotic channels) may remove all of the blood supply to the nerves in the infarcted area, as a result of which the nerves are unable to conduct painful stimuli coming from the ischemic area of myocardial infarction.

The mechanism by which pain of coronary artery disease is referred to the skin of the precordium and left upper limb has never been explained adequately. However, there is reason to believe that the innervations of the heart and of these skin segments or dermatomes arise embryologically from the same spinal segments. There is probably a common segmental origin for the vasomotor nerves in the walls of the blood vessels supplying the cardiac nerves and the branches of the brachial plexus. Ischemia or disease involving the blood supply to the cardiac nerves may cause vasospasm in the nerves of the precordium and upper limb as the mechanism for "referred pain."

THE CORONARY VEINS

Very little attention has been given in the past to the role of the coronary veins. It is well known that the systemic vascular system (composed of the aorta, its branches, the systemic capillaries, and the venae cavae) and the pulmonary vascular system may be involved separately or alternately by any change in cardiac efficiency. I have found it a useful concept to consider the coronary arteries, capillaries and veins as a third vascular system arising from one side of the heart and ending

on the other side. With such a concept, one can appreciate that increased venous pressure in the coronary veins by right-sided heart failure can be as important and harmful as is decreased flow into the coronary arteries by "forward failure" of the left ventricle. Such a situation would cause stasis in the myocardial capillaries with impaired nutrition or ischemia of the cardiac muscle. This may be part of a

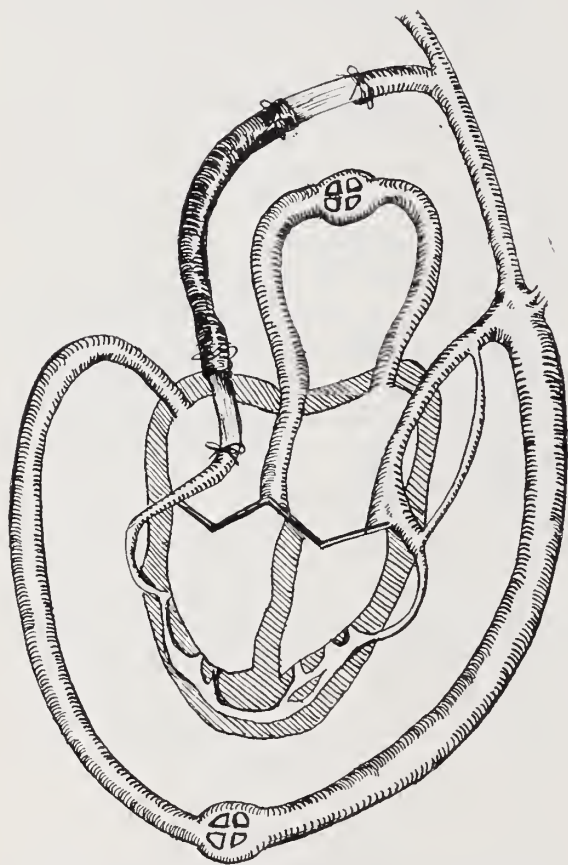


FIG. 3. Diagram of the circulation, with a cannula bringing arterial blood from an aortic branch to the coronary sinus.

vicious cycle causing hypertrophy or failure and aggravated by either.

The coronary veins may be affected by the same disorders as other veins, for example, thrombosis, inflammation, sclerosis, or compression. Careful search for such abnormalities may give the explanation for failure in patients having failure of undetermined cause.

Anomalies of the coronary sinus may be more common than is indicated by the rarely reported cases. I found 2 cases of "idiopathic cardiac hypertrophy" which had an anastomosis between the coronary sinus and the pulmonary veins.

More careful study of the myocardial veins should be made routinely in cases of infarction. Beck¹⁵ and Gross and their associates have found that occlusion of these veins may decrease the frequency or size of infarction following ligation of the coronary arteries subsequently.

It was suggested in 1898 by Pratt¹⁶ that nourishment of the myocardium might occur by retrograde flow into the coronary sinus. I¹⁷ conceived the idea of bringing a new blood supply to the myocardium by reversing the flow in the coronary veins. With the assistance of my wife and a medical student, R. S. Browne, I was able to do so by connecting the subclavian, carotid or internal mammary artery with the coronary sinus by means of a glass cannula (fig. 3). In 10 heparinized dogs with such an anastomosis the coronary veins became dilated and pulsatile and carried bright red arterial blood. These dogs survived under conditions of acute experiments as long as 27 hours, sometimes even after ligation of coronary arteries.

THE ATRIAL VESSELS

The blood supply of the atrial myocardium has been shown to be important only recently. Cushing, Feil and Stanton¹⁸ found a group of cases in which infarction of the atria occurred after coronary artery thrombosis, and I have seen 3 such cases. They also produced atrial infarction in dogs by ligating the atrial branches.

A study was begun recently with R. S. Browne of the fiber diameter and capillary concentration in the atrial walls of human hearts. Apparently, the fibers there become enlarged and push the capillaries apart in cardiac failure, just as occurs in the ventricles. Atrial ischemia may be the basic mechanism causing atrial arrhythmias, although this has not yet been proven.

THE THEBESIAN VESSELS

The routes by which the myocardium can obtain blood supply after occlusion of major coronary arteries include:

1. Thebesian or luminal vessels,
2. The extra-cardiac anastomoses,
3. The intercoronary anastomoses, and
4. The coronary sinus and veins.

Of these routes the intercoronary anastomoses probably are of most value until sclerosis or occlusion occurs in the anastomotic channels. Excellent studies on these vessels have been published by Schlesinger⁶ and Beck¹⁵ and their co-workers.

A reliable evaluation of the direction and magnitude of flow of blood in the extra-cardiac anastomoses has not been possible yet. These are vessels connecting the coronary arteries with other branches of the aorta, chiefly through anastomoses in the pericardium and around the vessels at the base of the heart. Their role has been indicated by Wearn and his co-workers.⁴

The Thebesian or luminal vessels are channels which communicate the lumen of the ventricles and atria with the coronary arteries, veins, capillaries and sinusoids. The cardiac luminal vessels, or so-called "Thebesian vessels," are channels discovered by Vieussens in 1706 and Thebesius in 1708. The structure of these vessels has been described very well in this country by Wearn and his co-workers.⁴ The luminal vessels are thought to be more abundant in the atria than in the ventricles, and in the right side than in the left side of the heart. Quantification of these minute openings is of course difficult. An interesting and possibly important observation of mine has been that the luminal vessels are larger and most abundant in the endocardium covering the atrioventricular conduction tissue. This might be expected by recalling the embryologic development of both the luminal vessels and the Purkinje apparatus. Both are considered to be

embryonic remains in the heart of previously more extensive systems on the inner surface of the cardiac walls.

I have endeavored to determine the direction of the flow through the Thebesian vessels of the 2 ventricles. These experiments were of 4 types:

1. I¹⁴ found that blood could flow through the Thebesian or luminal vessels from the myocardium into the lumen of the right ventricle by injecting Chicago Blue Dye into the cannulated coronary arteries following revival of the heart by perfusion with oxygenated Locke-Rosenheim solution. By looking through an incision made between the superior and inferior venae cavae, I could see the mouth of the coronary sinus and the lining of the right ventricle. In 40 of 43 human hearts under such conditions the dye appeared in the cavity of the right ventricle prior to its arrival in the coronary sinus, indicating the role of the Thebesian or luminal vessels in draining the right ventricular wall.

2. In successful experiments on 16 dogs, dye injected into the right ventricle was prevented from getting to the left side of the heart and so to the coronary arteries by the use of the bottle-and-bag device in the pulmonary artery (which prevents dye leaving one chamber from mixing with blood going to the next chamber), as illustrated in figure 4, or by ligation of the pulmonary veins at the time of injection. My co-workers and I¹⁹ found that blood (i.e., dye) could enter the myocardium after being injected into the cavity of the right ventricle only when the pressure in the right ventricle exceeded that in the left ventricle and therefore exceeded that in the coronary arteries. When dye injected into the right ventricle was under pressure lower than that of the left ventricle, no dye entered the myocardium from the cavity of the right ventricle. Conditions such as these probably do not occur ordinarily, but they may occur following extensive pulmonary infarction, in advanced pulmonary, aortic or mitral stenosis or insuffi-

ciency, with occlusion of the coronary arteries, or with left ventricular backward failure. In such conditions this mechanism (i.e., flow of blood from the right ventricle into the myocardium through the luminal vessels) may be a very important one in providing nourishment to the myocardium which otherwise would be rela-

or dye injected into the anterior descending coronary artery passed into the cavity of the left ventricle by way of the Thebesian or luminal vessels. Under conditions of unaltered pressure gradients in these experiments made successfully on 35 dogs, we injected dye into the cannulated anterior descending coronary artery and observed its appearance in the blood of the aorta. Precautions were taken to prevent the dye from reaching the aorta by way of the intercoronary arteries, the extra-cardiac anastomosis, or by way of the coronary veins and the right side of the heart; this was done by placing ligatures as indicated in the figure and by use of the bottle-and-bag device in the pulmonary artery.

In 3 other dogs this result was confirmed by injecting dye into the main coronary arteries which had been cannulated by tubes introduced into their ostia after being passed down the aorta through the carotid artery, also using the bottle-and-bag device in the pulmonary artery. Here again the dye appeared in the blood leaving the left ventricle under conditions in which the dye could have reached the left ventricle only by passing through the luminal or Thebesian vessels there.

4. Next I²¹ tried to determine if dye injected into the cavity of the left ventricle would enter the myocardium by way of the Thebesian or luminal vessels after ligation of the major coronary arteries. In 6 experiments on dogs' hearts beating in situ the main coronary arteries, the aorta, the venae cavae, the pulmonary arteries and the veins were ligated simultaneously, immediately before injection of dye into the cavity of the left ventricle by way of a cannula introduced by the left atrium (fig. 5). In these experiments the dye appeared immediately after injection in the ends of the coronary arteries and veins, usually appearing first near the apex of the left ventricle. The dye flowed toward the base of the heart in filling the coronary arteries and veins. For the injection of these experiments, pressures of 120 mm. Hg

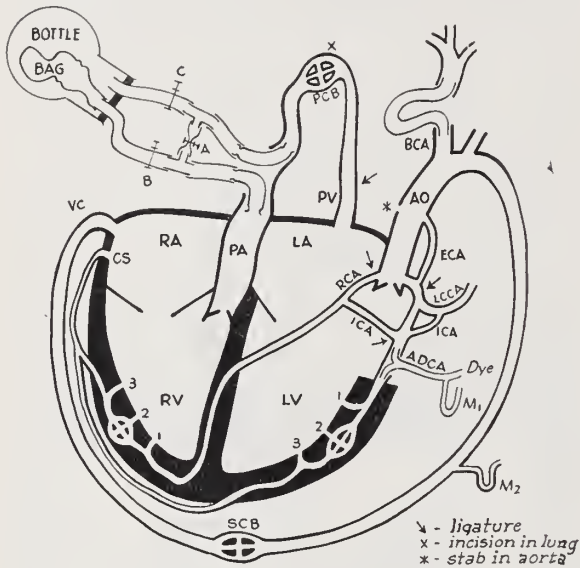


FIG. 4. Diagram of the relationships of the coronary arteries, veins and capillaries, the Thebesian (or luminal) vessels (1, 2, 3), the intercoronary anastomoses (ICA), the extracardiac anastomoses (ECA), the systemic capillary bed (SCB), pulmonary capillary bed (PCB), and the 4 cardiac chambers; also the bottle-and-bag device in the pulmonary artery (PA), and the site of ligatures described in the text. (RA, right atrium; RV, right ventricle; PV, pulmonary veins; LA, left atrium; LV, left ventricle; AO, aorta; BCA, brachiocephalic arteries with glass cannula; RCA, right coronary artery; LCCA, left circumflex coronary artery; ADCA, anterior descending coronary artery; VC, venae cavae; M₁ and M₂, manometers; 1, arterio-luminal vessels; 2, capillary-sinusoido-luminal vessels; 3, veno-luminal vessels; A, B and C, valves.)

tively ischemic. The fact that the blood in the right ventricle is less well oxygenated than that of the left ventricle would make this source for accessory nourishment of less theoretical value than if it came from the left side of the heart.

3. By experiments such as are diagrammed in figure 4, my co-workers and I²⁰ found that blood

were used. In other experiments using dead hearts in which rigor mortis had been dissipated by massage in warm saline, both coronary arteries were ligated and dye was injected into the left ventricular cavity through a cannula introduced by way of the aorta. Dye injected with a pressure of 35 mm. Hg appeared at once in numerous spots around the apical ends of the smaller coronary arteries and veins. From

from human beings without heart disease and on those who had varying degrees of coronary artery disease, and in animals with induced coronary artery stenosis. Such studies would seem to be of really crucial importance.

It seems probable that in hearts which are the site of chronic coronary artery disease, nourishment of the myocardium may be assisted by dilatation of the luminal or so-called Thebesian vessels. That this occurs and is of clinical importance is suggested by the frequent observation that the inner portion of the myocardium next to the endocardium remains intact despite necrosis of the more superficial myocardium following coronary artery thrombosis. In cases in which the Thebesian vessels do not adequately nourish the endocardial portion of the infarcted segment, the infarct involves the endocardium. Then mural thrombosis occurs with its terrible hazards to the patient because of removal of the last route of collateral circulation to the heart and the possibility of fatal embolism.

Still another common observation favoring the belief that the Thebesian vessels are important in the nourishment of the myocardium is the finding that infarction involving the right ventricle is extremely rare, despite the observation that occlusion of the right coronary artery is practically as common as is occlusion of the left coronary artery. The right ventricle is so much thinner than the left ventricle that the Thebesian vessels are able to nourish the entire thickness of the right ventricular wall and prevent infarction after major artery occlusion, whereas the portion of the left ventricular wall supplied by the Thebesian vessels is only a small part of its entire thickness. Loubé and I²² have recently encountered 1 case in which infarction of the wall of the right ventricle occurred as the chief lesion. This is the first such case of major infarction of the right ventricle which we have encountered in 16 years of medical work with special interest in cardiology. In this patient there was only 1

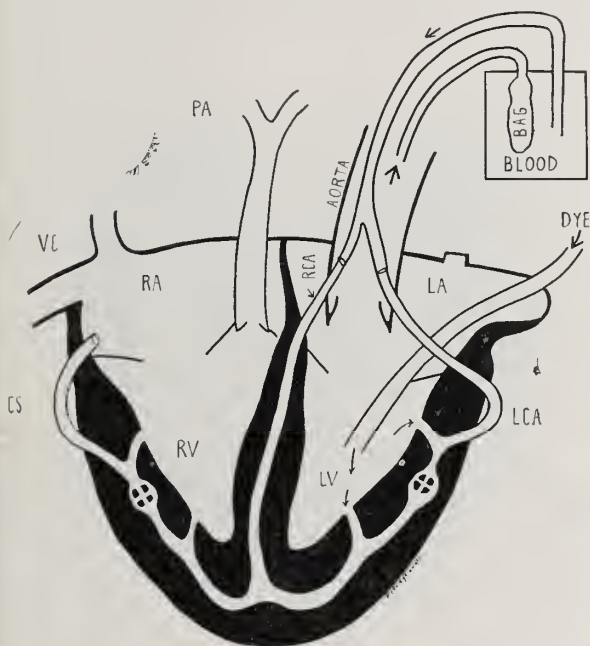


FIG. 5. Diagram of the cardiac vessels, showing how dye injected into the left ventricular cavity may reach the myocardium through the luminal or Thebesian vessels. Both coronary arteries receive blood from the bottle-and-bag device which traps the dye. Legends as in figure 4.

these observations I concluded that the luminal or Thebesian vessels can conduct blood from the cavity of the left ventricle into the myocardium under circumstances in which the pressure in the ventricle is greater than the pressure in the coronary arteries.

It must be borne in mind that each of these last 3 types of experiments was conducted on the hearts of apparently normal animals. At the present time we are trying to collect data on similar experiments performed upon hearts

coronary artery, the right, from which the entire heart derived its blood supply. Thrombosis occurred in the main right branch of the common trunk, and in several of the smaller secondary branches of the homologue of the right coronary artery.

The use of anticoagulants was necessary for these experiments. Usually Liquaemin was used, a form of heparin furnished by Roche-Organon, Inc. This was entirely satisfactory in preventing coagulation of the blood even in the small cannulae used.

The importance of the accessory channels available to substitute for an occluded coronary artery would suggest the desirability of using anticoagulants (e.g., Liquaemin) in patients having coronary thrombosis. If anticoagulant therapy could be started before the thrombus reached its full size, and if there were not so often an underlying basis for recurrent thrombosis in the coronary arteries, time might be allowed for dilatation of the accessory channels. I know of no really adequate controlled studies of the use of heparin in preventing coronary artery thrombosis, but such studies are needed. The use of any available anticoagulant requires very carefully controlled observations.

SUBINTIMAL HEMORRHAGE

In recent years the existence of minute blood vessels in the subintimal layer of the coronary arteries has been established. Wartman,²³ Paterson²⁴ and others have found cases in which rupture of these little vessels resulted in a small "dissecting aneurysm" in the subintimal layer and caused occlusion of the lumen of the coronary artery. The incidence of subintimal hemorrhage as a cause of coronary artery occlusion has been placed as high as 60 per cent of such cases. This indicates the need for more carefully controlled study of the thrombosed artery than is usual, with serial sections if needed.

It has been surmised that subintimal hemorrhage may be caused by embolism or erosion of

an atheromatous area into a subintimal vessel. Another mechanism, which I wish to propose, is that angulation of a semi-rigid coronary artery by the beating of the heart would in time cause excessive bending, stretching and then rupture of these subintimal vessels.

VESSELS OF THE VALVES

Wearn,²⁵ Gross and their collaborators have studied the blood supply of the cardiac valves with differing conclusions. One group believes the valves to be relatively avascular in the normal mature stage, and that vascularity indicates the invasion of new vessels and a reaction to disease. The other group concludes that some measure of vascularity in mature valves may be due to persistence of normal vessels from infancy. In either case these small vessels may serve as a place for thrombosis or embolism, followed by endocarditis.

LYMPHATICS OF THE HEART

Although anatomists have demonstrated that there is an abundance of lymphatic vessels in the heart, no studies of the clinical or pathologic importance of this system have come to my attention. The cardiac lymphatics are arranged in 3 plexuses: (1) a subendocardial plexus, bathing and draining the important atrioventricular conduction tissue, (2) an intra-myocardial plexus surrounding the myocardial fibers and paralleling the vascular capillaries, draining the subendocardial plexus and entering the epicardial plexus, and (3) the epicardial plexus which unites into 3 main channels paralleling the coronary veins. All of these lymphatic channels terminate in a single main cardiac lymphatic vessel which passes to the left of the pulmonary artery into the peribronchial lymphatic nodes. In experiments on the beating hearts of dogs I injected India ink into the myocardium (fig. 6). Within the short time of 1 or 2 beats of the heart the dye passed from the myocardial plexus into the

epicardial plexus and along the principal paravenous channels to the main cardiac lymphatic vessel. It seems quite likely that such an active system must have some role to play in the metabolism of the cardiac muscle.

One may surmise that sclerosis or obstruction of the lymphatic channels may contribute to the development of myocardial lymphedema and hypertrophy or failure. Experiments are now under way to test the effect of chronically occluding the cardiac lymphatic vessels. It

found that the cardiac muscle fibers were smaller than normal in each case. This means that the compressed heart in pericardial disease undergoes atrophy of disuse. The mechanism of this atrophy may be partly obstruction of the small blood and lymphatic vessels by the fibrous adhesions, which impairs the nourishment of the fibers.

CONCLUSIONS

As a result of a variety of experiments conducted with several assistants and collaborators I have come to regard hypertrophy of the heart as an evidence of heart failure and believe that it should be treated with the measures available for treating heart failure of more obvious degree. I believe that heart failure should be treated by immediate digitalization. This may be done safely with a single dose of one of the purified crystallized digitalis glycosides such as Digoxin, Digilanid, Digitaline Nativelle, Cedilanid or Digitoxin. Such treatment should be instituted before obvious congestive heart failure develops, if possible, when organic heart disease with significant enlargement is detected or when the patient is facing a strain such as operation or parturition.

The Thebesian or luminal vessels connecting the coronary vessels with the ventricular cavities have been found to be capable of conducting blood in either direction, that is, either from the cavity into the myocardium or from the myocardium into the cavity, depending upon the differential pressure gradient. In cases of coronary artery disease, pulmonary embolism, extensive pulmonary disease of any type, or in mitral, pulmonary or aortic stenosis, the Thebesian or luminal vessels can serve an important role in nourishing the myocardium. In myocardial ischemia of any cause the coronary veins may aid in the nourishment of the myocardium by retrograde flow and, experimentally, arterial blood could be brought to the ischemic myocardium through the coronary sinus.

(Continued on page 529)

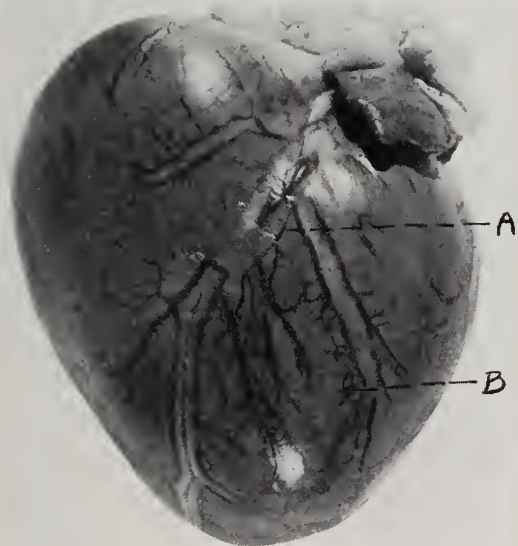


FIG. 6. Photograph of the anterior epicardial lymphatic vessels (A) draining an area (B), where India ink was injected (dog's heart).

seems probable that the cardiac lymphatic vessels and the veins may easily be occluded by pressure upon them, resulting from either dilatation of the heart and pressure against the pericardium, by cardiac tamponade, by pericardial effusion, by angulation of the heart at its axis, or by the formation of new tissue as a result of fibrosis, inflammation or neoplasm.

ATROPHY OF DISUSE

In a series of human and dog hearts which were chronically compressed, Beck and I²⁶

AN ANALYSIS OF THE USE OF PENTOTHAL IN SEVEN THOUSAND FOUR HUNDRED ANESTHETICS

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FROM mid-November 1943 until January 1945 9,779 anesthetic procedures have been performed at a general hospital in an overseas theater. Of this number, 7,494 or 76.6 per cent have been general anesthetics (table 1). In 7,404 cases (98.8 per cent) of the general anesthetics administered, pentothal has been used at some stage of the operation.

TABLE 1
Analysis of Anesthetics

	TYPE OF ANESTHETICS	NUMBER OF CASES	PERCENTAGE OF ALL ANESTHETICS
I	General with pentothal....	7404	75.7
	General without pentothal..	90	0.9
II	Local infiltration anesthetics	1905	19.5
III	Spinal and regional anesthetics	380	3.9
Total.....		9779	100.0

last, includes spinal, local infiltration, and regional anesthetics supplemented by the use of pentothal. These groups will be discussed in sequence.

TABLE 2
Analysis of Pentothal Anesthetics

GROUP	TYPE OF ANESTHETIC	NUMBER OF CASES	PERCENTAGE OF PENTOTHAL ANESTHETICS	PERCENTAGE OF GENERAL ANESTHETICS	PERCENTAGE OF ALL ANESTHETICS
A	Pentothal	5992	80.9	80.0	61.3
B	Pentothal, nitrous oxide oxygen	391	5.3	5.2	4.0
C	Pentothal, nitrous oxide-oxygen, ether	353	4.8	4.7	3.6
D	Pentothal, drop ether	571	7.7	7.6	5.8
E	Pentothal and spinal, local or regional	97	1.3	1.3	0.9
Total.....		7404			

GROUP A

This series of pentothal anesthetics, which constitutes 75.7 per cent of the entire series for the period under study, has been divided into 5 groups for the purpose of analysis (table 2). Group A is made up of those cases in which pentothal with or without oxygen was the sole anesthetic agent. Group B consists of a series of cases in which pentothal and nitrous oxide-oxygen in combination was used. Group C contains those cases in which pentothal and nitrous oxide-oxygen and ether vapor were administered by inhalation. Group D consists of a series of anesthetics in which pentothal was followed by open-drop ether. Group E, the

In 5,992 cases, totalling 80 per cent of the general anesthetics administered, pentothal was the sole anesthetic used. The greater percentage of this number, as shown in table 3 (column A) is made up of such operations as suturing of wounds, débridements, skin-grafting procedures, removal of foreign bodies, incision and drainage of abscesses, and reduction of fractures. These have been cases in which only moderate muscular relaxation was required, and which, for the most part, did not extend over 30 to 45 minutes' operating time and which did not require more than 2 grams of pentothal. These

limitations as to time and amount of drug have been arbitrarily set by the department after observation of a large number of cases in order

TABLE 3
Classification of Operations

OPERATION	NUMBER OF CASES				
	A	B	C	D	E
Amputation.....	41	15	13	29	
Aneurysm, or A-V-fistula, excision of...		1	4	2	
Appendectomy.....		3	2		10
Application of cast or redressing.....	124	3		2	
Artery or vein, ligation of.....	17	3	5	12	1
Arthrotomy or osteotomy.....	18	3	3	10	1
Bronchoscopy, or laryngoscopy.....	14				2
Caldwell-luc (sinus drainage).....	27				
Cholecystectomy.....		1	10		
Circumcision.....	37	7			
Colostomy, closure of.....	11	6	21	7	13
Craniotomy.....	17		2	6	1
Débridement of wounds.....	401	7	9	31	
Eye, enucleation of.....	26		1		
Fasciotomy.....	10			6	
Foreign body, removal of.....	201	10	7	16	3
Fracture, closed reduction.....	132			3	
Fracture, open reduction.....	33	5	27	81	1
Fracture, skeletal traction for.....	154	3	6	19	
Herniorrhaphy.....	3	2	4	2	17
Hydrocelectomy and varicocelectomy...		12			1
Incision and drainage of abscess.....	201	8	5	4	
Laminectomy.....	2	2	3	2	
Laparotomy.....			13	7	1
Lumbar sympathetic ganglionectomy...	1	3	13		23
Nephrectomy.....			7		
Neurolysis or suture of nerve.....	1	8	4	9	2
Sequestrectomy.....	27	2		10	
Skin graft.....	492	67	21	94	2
Suture of wounds (secondary).....	3790	155	45	185	6
Tendon or ligament, repair of.....	6	3	5	5	4
Thoracotomy (simple).....	22	32			
Thoracotomy for decortication or re- moval of foreign body from lung, pleura, mediastinum, or heart	1		109		
Tumor, excision of.....	33	15	4	2	2
Miscellaneous.....	70	15	12	27	7
Totals.....	5992	391	353	571	97

to minimize, in so far as possible, the dangers of overdosage. Likewise, as a safety factor, in all cases in which pentothal has been used for a period exceeding 10 minutes, oxygen has been given, either by catheter through an airway or by B. L. B. mask. The largest dose of pentothal

administered in this group was 2.8 grams for a laminectomy in 1 case and the removal of a tumor in a second. Table 4 (column A) shows the distribution of the cases with regard to the amount of drug administered. Nearly 80 per

TABLE 4
Relationship between Amount of Pentothal and Number of Cases

AMOUNT OF DRUG	A		B		C		D	
	No. of cases	Per cent	No. of cases	Per cent	No. of cases	Per cent	No. of cases	Per cent
grams								
0.0 to 0.4	100	2	1	0+	289	87	372	69
0.5 to 1.0	2541	43	159	42				
1.1 to 1.5	2261	39	142	38				
1.6 to 2.0	857	14	70	18½	43	13	167	31
Above 2.0	74	1	7	1½				

TABLE 5
Relationship between Length of Operation and Number of Cases

LENGTH OF OPERATION	A		B		C		D	
	No. of cases	Per cent	No. of cases	Per cent	No. of cases	Per cent	No. of cases	Per cent
minutes								
0 to 30	2922	67	130	43	14	5	51	11
30 to 45	640	15	59	19				
45 to 60	394	9	39	16	67	23	115	24
60 to 90	259	6	47	12	80	27	121	26
90 to 120					63	22	103	21
Above 120	79	2	18	9	68	23	85	18

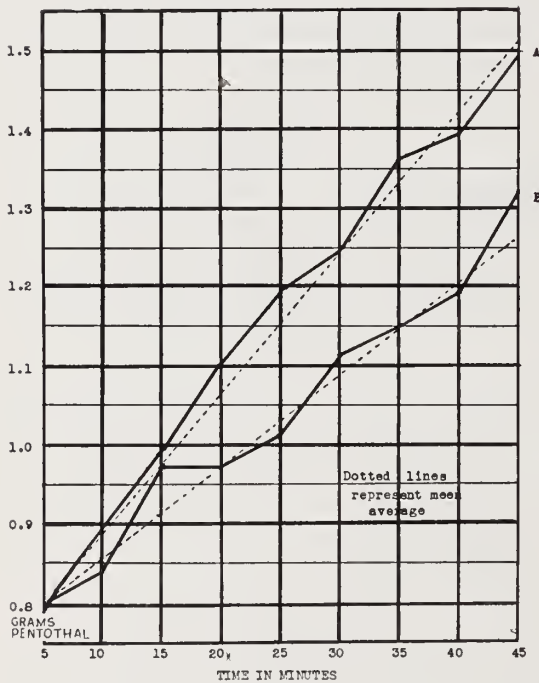
cent of these cases received amounts of pentothal in the range between 0.5 and 1.5 grams. Table 5 (column A) shows the relationship between the number of cases and the duration of the operation. Sixty-seven per cent of the anesthetics were completed in less than 30 minutes, and in more than 80 per cent of the cases the time was less than 45 minutes.

GROUP B

In 391 cases (5.2 per cent) in which general anesthetics were used, pentothal and nitrous oxide-oxygen were administered in combination. This group includes 2 classes of cases about equally divided in number. The first constitutes a series of cases in which the gas-oxygen mixture was used as a supplement to pentothal when

GRAPH 1

Comparison of the Amount of Drug—Length of Operation Relationship between Pentothal and Pentothal Nitrous Oxide Anesthesia



the latter did not provide satisfactory anesthesia for the surgery involved, or when continued anesthesia was necessary after 2.0 grams of pentothal had been administered. The second is composed of cases in which the pentothal and gas-oxygen were used as complementary agents. This method proved to be most satisfactory since less pentothal was required after induction, smoother anesthesia was obtained, and the patient was better controlled,

with the respiratory exchange under constant, accurate observation. The percentages of gas and oxygen used in this method varied from 70 per cent nitrous oxide and 30 per cent oxygen to 50 per cent of each in order that adequate oxygenation was always maintained. In this group (table 3, column B) closure of wounds, skin grafts, reduction of fractures, débridement of wounds and amputations comprise the bulk of the cases. As in group A (see table 4, column B) in 80 per cent of the cases between 0.5 and 1.5 grams of pentothal was required, whereas there was an increase of 24 per cent in the cases of more than 30 minutes' duration over the former group (table 5, column B).

By plotting the amount of pentothal required for anesthesia against the length of the operation up to a 45-minute period in the largest class of cases, the closure of wounds, in both groups A and B an interesting correlation was noted. The amount of pentothal required for induction was the same in each group, averaging 0.72 grams (graph 1). From this point on, however, the effect of the combined inhalation anesthesia on the amount of pentothal required is quite apparent, for there is a rather uniform divergence of the two curves. At the end of the 45-minute period the mean difference amounts to 0.25 grams, or an average of 0.032 gram per 5-minute period. In other words, the amount of pentothal required to give an average anesthetic of 30 minutes is sufficient, when used in combination with nitrous oxide-oxygen by inhalation, to give an anesthetic of approximately 42 minutes' duration. The series of cases used for this comparison is large enough in Group A to equalize the effect of the variable sensitivity of different body areas as well as the individual differences in tolerance to pentothal. The regularity of the curve in the case of Group A, plotted on the basis of nearly 2,500 cases (1,900 in the first 25-minute period) emphasizes this, in comparison to curve B, plotted on a basis of less than 100 cases.

GROUP C

In 353 cases, 4.7 per cent of the general anesthetics, pentothal-nitrous oxide-oxygen-ether vapor anesthesia was used (table 3, column C). In 43 cases of this series inhalation anesthesia was used to supplement pentothal when the latter gave inadequate anesthesia or when it was deemed inadvisable to continue prolonged use of pentothal. In 289 cases (87 per cent) pentothal was used as an induction agent for an inhalation anesthetic (table 4, column C). Included in Group C were 152 cases of endotracheal anesthesia, more than two thirds of which were for major chest surgery. The average amount of pentothal required for induction by this method was 0.6 gram.

In 72 per cent of the operations in this series (table 5, column C) the operative time was more than 1 hour.

GROUP D

Pentothal combined with open-drop ether was used for 571 operations (table 3, column D). Major orthopedic operations, suturing of multiple wounds, and lengthy skin-grafting procedures compose the bulk of this series. These include 167 cases (31 per cent) in which ether was used to supplement the pentothal because of arbitrary limitations set as to time or amount of pentothal administered, or the extent of the surgery involved, and 372 cases (69 per cent) in which pentothal was used as an induction agent preliminary to drop ether (table 4, column D). The average amount of pentothal required for smooth induction and transition to drop ether anesthesia was 0.75 gram, slightly higher than in group C.

The operating time in this series was over 1 hour in 65 per cent of the total number (table 5, column D).

GROUP E

Included in this series are 81 cases of pentothal anesthesia combined with spinal. This

amounts to 16.8 per cent of the total spinal anesthetics administered. In approximately half of these pentothal was used to supplement spinal anesthetics which were inadequate either in depth or duration of anesthesia. In the remainder pentothal was administered in small doses, usually not exceeding 0.5 gram, coincident with the beginning of the operation, to provide sedation without obliteration of the reflexes. Nausea was a complicating factor in only 1 case among the patients thus treated, while among those not receiving pentothal in this manner, the number has run above 10 per cent.

DISCUSSION

Premedication for the majority of the patients receiving pentothal has been morphine sulphate, grain 1/4 (0.015 Gm.) and atropine sulphate, grain 1/150 (0.4 milligram) hypodermically. The time interval between the administration of the premedication and the anesthetic has varied from 10 minutes to 2 hours. In addition to the above, a number of patients have received Nembutal or Seconal in doses of 0.1 to 0.2 gram.

Complications have been few and for the most part minor. Slow administration of pentothal in a 2.5 per cent solution, maintenance of a patent airway, and the liberal use of oxygen have reduced to a minimum the incidence of apnea, respiratory depression, and cyanosis. Coughing and spasm of the glottis have occurred in a small percentage of cases, both during the induction and recovery stages, and in most cases they could be traced to unsatisfactory premedication or irritation produced either by a collection of mucus in the region of the larynx, too early introduction of an airway, or actual contact with the vocal cords. A few cases of partial atelectasis have occurred, but there have been no cases of postoperative pneumonia. Two deaths attributable to anesthesia have occurred, giving a mortality rate 0.204 per 1,000 (0.002 per cent). The first, following pentothal anesthesia, was due to asphyxia

subsequent to respiratory obstruction, occurring while the patient was in transit from the operating room to the ward with untrained personnel in attendance. This death, scored against pentothal, might have occurred with any inhalation anesthetic in the same fashion. The second, a case induced with 0.4 gram of pentothal, died on the operating table of circulatory collapse while receiving nitrous oxide-oxygen-ether anesthesia 25 minutes after induction, the cause of which was not revealed by postmortem examination.

Study of this series of pentothal anesthetics brings out certain pertinent points with regard to the advantages and limitations of pentothal anesthesia, some of which reëmpHASize statements previously published in the literature.

Contraindications to the use of pentothal anesthesia are few. Primarily, they are shock, marked anemia, liver damage, and conditions predisposing to respiratory obstruction or anoxia.

Adequate premedication is most important. The patient should be atropinized hypodermically 30 to 45 minutes before operation, or preferably by the intravenous route 10 minutes prior to surgery. The use of morphine diminishes the amount of pentothal required and does not appear to depress respiration unduly. Premedication with barbiturates in addition to morphine, especially in doses above 0.1 gram, depresses respiration, predisposes to a period of apnea or anoxia upon the administration of pentothal, and delays the return of normal reflexes during the recovery period.

The maintenance of a patent airway and adequate respiratory exchange are essential, and the use of oxygen, preferably in all cases, is beneficial in preventing respiratory complications. Likewise, close observation of the unconscious patient during the period of recovery is just as important as during the operative stage.

Pentothal anesthesia is most satisfactory for operations requiring moderate muscular relaxation, the duration of which is not over 45 minutes. The rapid, quiet period of induction, together with the simplicity of administration and the infrequency of undesirable after-effects, enhances its value.

The combined usage of nitrous oxide-oxygen by inhalation and pentothal increases the range of usefulness both as to the type and duration of operations which can be performed, and gives a smoother, better controlled, and hence safer anesthetic than when pentothal alone is used.

Pentothal as an induction agent for inhalation anesthesia reduces the time required for induction of the patient to the surgical level, and by elimination of the excitement stage benefits both the patient and the anesthetist. The use of pentothal in this manner further reduces the contraindications to the drug. Operations within the mouth or involving the larynx, trachea and bronchi can be performed with ease under combined pentothal-ether anesthesia, whereas pentothal as the sole anesthetic or in combination with topical anesthetics has proved most unsatisfactory from the anesthetic standpoint.

Pentothal in small sedative doses, used in combination with spinal anesthesia, is most beneficial, particularly in reducing the incidence of nausea, vomiting and other undesirable symptoms of novocaine reaction. Likewise, as a supplement to inadequate spinal anesthesia, pentothal has proved superior in most cases to the other anesthetic agents available.

In conclusion, a study of more than 7,400 cases of pentothal anesthesia, with a discussion of methods of administration and recognition of its limitations, is of value in the allocation of this drug to its proper place in the field of anesthesia.

ACUTE ANTERIOR POLIOMYELITIS: DIAGNOSIS, DIFFERENTIAL DIAGNOSIS AND TREATMENT OF BULBAR PARALYSIS AND RESPIRATORY FAILURE*†

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 IN A typical case of acute anterior poliomyelitis there is very little difficulty in arriving at a correct diagnosis. There is a quite characteristic history with rather sudden onset of headache, fever and vomiting, followed after a short interval by definite stiffness of the neck. In a quarter to one half of the patients there will be a history of a mild respiratory tract infection with slight fever, lasting not over 48 hours, from two to four days before the onset of the more severe illness. Examination of the typical patient shows an acutely ill, but alert and coöperative patient with, as a rule, a moderate fever (around 101 to 103° F.), a flushed face and frequently a circumoral pallor, a neck and back so rigid that when one lifts the head from the occiput the patient's whole neck and trunk hinges up from the buttocks. Also in almost all patients there is a positive Kernig's sign, or, to use more recent terminology, hamstring spasm. Muscular paralysis or weakness of varying degrees may be present. If there is no weakness or paralysis, the tendon reflexes will be found to be normal or slightly exaggerated; there will be no sensory nerve changes. If weakness or paralysis is present the tendon reflexes are diminished or absent, there will be tenderness to deep palpation over the bellies of the affected muscles, and there may be some hyperesthesia.

The cerebrospinal fluid, in the typical patient,

shows considerable variation from the normal. As the lumbar puncture is done, the fluid will be found to be under increased tension and slightly opalescent or cloudy, although it may be entirely clear. Microscopic examination usually shows an increased number of leukocytes with the total count averaging 200 to 400 per cu. mm., although with extreme limits of 0 and 2,000 cells. Early in the disease the cells are predominately of the polymorphonuclear series, but after a short and variable time they are of the mononuclear varieties, chiefly lymphocytes. There is a definite increase in the cerebrospinal fluid protein content, the dextrose content is normal or increased, and the chlorides are normal, or, in the case of a patient who has vomited excessively, somewhat reduced.

This typical picture is found in perhaps three quarters of all patients with poliomyelitis. The remaining one fourth of cases are atypical and, to us, increasingly difficult to diagnose. The picture is extremely bizarre in many, and there are a number of other conditions which at times may cause confusion in the diagnosis. In general, however, we can be guided by 4 cardinal factors: the history, the presence or absence of muscle spasm or of paralysis, and the cerebrospinal fluid findings (chart 1). We frequently are required to make a diagnosis of acute anterior poliomyelitis on the basis of a definite history, physical characteristics, and the finding of muscle paresis or paralysis even though the cerebrospinal fluid, examined frequently throughout the early course

* From the Infectious Disease Service, Gallinger Municipal Hospital, Washington, D. C.

† Read before the Society, October 10, 1945.

of the disease, is entirely normal. Likewise in the presence of a characteristic history, if there is a pathologic spinal fluid, however slight the abnormalities, we will diagnose poliomyelitis without muscle weakness or spasm, provided other diseases can be eliminated. We have been unwilling to diagnose poliomyelitis when the cerebrospinal fluid is within normal limits and there is no definite muscle weakness, regardless of the history and the presence of muscle spasm. (In making this reservation, I am quite aware of the probability that there are many subclinical cases of poliomyelitis for each case definitely diagnosed. However, at present, we have no means of making a clinical diagnosis on such patients.)

CHART 1
Essential Findings for Diagnosis of Poliomyelitis

FINDINGS				DIAGNOSIS
History	Spasm	Paralysis	Abnormal C.S.F.	
+	+	+	+	+
+	±	—	+	+
+	±	+	—	+
+	+	—	—	—

During the season in which poliomyelitis is usually prevalent many patients are seen in whom the diagnosis of poliomyelitis must be entertained and eliminated. For convenience, these patients can be grouped into 3 categories (table 1). The most difficult diagnosis encountered is that in a child between 1 and 4 years of age with a limp. We must be careful in eliciting the history and meticulous in the physical examination. If there is no other cause for the limp (table 1, group I) the diagnosis of poliomyelitis can be eliminated only after the cerebrospinal fluid has been repeatedly examined and found to be normal, the tendon reflexes have remained constantly normal over several days, and, usually, the limp has disappeared.

Of almost equal perplexity is that group of patients (table 1, group II) with cerebrospinal fluid changes simulating those usually found in poliomyelitis. Pyogenic meningitis must be considered in any patient in whom there are 75 per cent or more polymorphonuclear cells, particularly when the total cell count is over 500 per cu. mm., if paralysis is not evident. We have seen several patients with such a picture who eventually proved to have poliomyelitis. However, the danger of delay in

TABLE 1
Conditions Simulating Acute Anterior Poliomyelitis

- I. Actual or apparent muscle weakness is present, the cerebrospinal fluid is normal.
 - A. Trauma—bruise, tight shoes, hematoma, etc.
 - B. Infection—arthritis, osteomyelitis, lymphadenitis, cellulitis, etc.
 - C. Toxic neuritis—with lead poisoning, or following diphtheria
 - D. Vitamin deficiency disease: Scurvy
- II. No evident muscle weakness, but with an abnormal cerebrospinal fluid.
 - A. Pyogenic meningitis
 - B. Serous meningitis
 - 1. Virus diseases: as lymphocytic choriomeningitis, mumps meningoencephalitis, and other encephalitides
 - 2. Bacterial diseases: as tuberculous meningitis
 - 3. Spirochetal diseases: as syphilis or Weil's disease
 - 4. Toxic diseases: lead encephalitis
- III. No evident muscle weakness and with a normal cerebrospinal fluid.
 - A. Meningism from any acute infection
 - B. Hysteria
 - C. Miscellaneous causes

treating purulent meningitis is so great that we feel that, in case of doubt, the patient's best interest is served by considering him as having meningitis until proved otherwise. If the present theory that the sulfonamide drugs aggravate poliomyelitis is proved to be correct, this reasoning may have to be revised. At present it is almost impossible to differentiate immediately nonparalytic poliomyelitis from other forms of acute serous meningitis, i.e., those with a predominance of lymphocytic

cells in the spinal fluid. If the history indicates the recent experience of, or exposure to, mumps or other virus disease that frequently is accompanied by meningoencephalitis, such a diagnosis must be considered most carefully. Syphilis can be differentiated from poliomyelitis by serologic tests, tuberculous meningitis by the course of the disease and by the demonstration of tubercle bacilli in the spinal fluid, and lead encephalitis by the roentgenographic and blood findings.¹ With the other primary virus diseases, however, there often is no point of definite differentiation except the later development of positive complement fixation or virus antibodies, processes that take weeks or months to determine.

In that group of patients in whom there is neither muscle weakness nor cerebrospinal fluid changes, a short period of observation usually suffices to demonstrate the primary focus of infection in patients with meningism, while those with hysteria usually respond to suggestion and psychotherapy.

The space allotted is too short for a complete discussion of the treatment of the usual manifestations of poliomyelitis. Instead, the treatment of those more serious complications, respiratory failure and bulbar paralysis, will be discussed briefly. According to Wilson² there are 3 types of respiratory failure in poliomyelitis:

1. Spinal Paralysis—involvement of muscles of respiration
2. Bulbar Paralysis
 - A. Pharyngeal paralysis—due to exhaustion from attempting to breathe without aspirating mucus
 - B. Involvement of central respiratory center.

The first of these, failure of the muscles of respiration, must be treated with the mechanical respirator. If there are no other vital centers involved, such patients make a good immediate response to the respirator and obtain marked relief. In my opinion, if any patient shows definite paralysis of any of the muscles

of respiration he should be given an immediate trial in the respirator, and in the majority of instances should remain in the machine until his temperature is entirely normal. Thereafter his clinical condition determines the time of his removal. When a patient is being weaned from the respirator, he never should be forced, but should be returned to the machine before fatigue sets in. This is particularly true when the patient first seems to be able to be out of the respirator for the whole day. If he has been dependent on the machine for more than a few days, he will have a very low reserve which may suddenly be exhausted. Therefore, with patients of this type it is highly desirable to have a daily rest period of from 2 to 4 hours in the respirator for several days, or even weeks, after he seems to be able to live comfortably with his own respiratory efforts. Furthermore, any acute infection may cause a recurrent respiratory failure in any patients who have had a long stay in a respirator, and great care must be exercised in divorcing them completely from the machines.

The respiratory failure seen in simple "bulbar" poliomyelitis rarely will be benefited by the respirator, and it may be remarkably aggravated by this method of treatment. Of first importance in this group of patients are those with pharyngeal paralysis. They accumulate large quantities of unswallowed mucus in the lower pharynx, and when they inspire they aspirate this mucus. Consequently, their sensorium being normal, they try to expel the mucus by a cough or forceful expiration. This train of events, constantly repeated, leads to a shallow, ineffective respiration, anoxia, and exhaustion. The obvious treatment for this condition is postural drainage, the patient being put into the Trendelenburg position with elevation of the bed to extreme degrees, and gentle aspiration of the mucus from the pharynx. Having the patient lie on his face helps the drainage considerably, and reduces the need for suction.

The other type of respiratory failure commonly seen is that found in bulbar poliomyelitis where

there is involvement of the respiratory centers in the medulla. This is characterized by a totally irregular respiration, both as to rate and as to depth. This type of respiratory failure frequently closely resembles that seen in pharyngeal paralysis, being usually ushered in when there is a bout of choking, vomiting, or other cause of severe anoxia in patients with bulbar poliomyelitis, and may be almost indistinguishable from it. However, in this central type of involvement, the mechanics of respiration are intact, but the stimuli from the medulla are extremely variable. Consequently the patient is totally unable to breathe with the respirator, and frequently his inspiratory efforts are totally at variance with those of the respirator. This aggravates the patient's apprehension and fear, which are extreme at best, increases anoxia, and rapidly worsens the condition. Treatment in these patients usually is futile. It must be directed at soothing and calming the patient, and maintaining a clear airway. In a great majority of such patients, however, the pulse rate rapidly increases and the patient dies with heart failure.

Finally, there is the group of patients with both spinal and bulbar poliomyelitis, in which there is respiratory failure from paralysis of the primary muscles of respiration, with evidences of medullary involvement. In such a situation, if the peripheral muscular involvement is slight, the patient should be observed closely, and maintained without, but beside, the respirator as long as he is comfortable. If there is discomfort or any appreciable degree of anoxia, the respirator must be used, but it must be so tilted as to give good postural drainage. For some patients, if there is excessive accumulation of mucus, tracheotomy has been recommended.³ We have had little success with this procedure.

Patients with bulbar poliomyelitis without respiratory failure are a different and extremely serious problem, since they all are potential cases of failure from involvement of the respiratory center. The advent of this crisis

usually is ushered in by a bout of choking, gagging, or other anoxia-producing episode. Therefore, if such episodes can be eliminated entirely during the acute, febrile stages of bulbar poliomyelitis, there is excellent prospect of carrying the patient through to complete recovery. To this end, we eliminate all food and fluids by mouth and by rectum. If there is any pharyngeal paralysis the patient is placed in the Trendelenburg position, special nursing is secured, and aspiration of mucus is carried out as often as is necessary to maintain a free airway. The patient's nutrition is maintained by the use of pyrogen-free fluids given either intravenously or subcutaneously. This schedule is adhered to very rigidly until the patient has been afebrile for at least 48 hours. Then rectal fluids are started, and after another day sips of water are given by mouth under careful supervision. If the patient is able to swallow, clear fluids, full liquids, and finally a soft diet are allowed as rapidly as the patient can handle them. If the patient is unable to swallow, rectal and parenteral feedings are continued for 2 or 3 days, when another trial is made. If the patient still is unable to swallow, gavage feedings are instituted, with the same gradual increase in food being given.

TABLE 2
Results in Treating Bulbar and Respiratory Poliomyelitis

TYPE	NO. TREATED	EARLY DEATH	LATE DEATH	RE- COVERED
Bulbar involvement only.....	24	2	0	22
Spinal respiratory failure only.....	20	1	7	12
Spinal respiratory failure, and bulbar involvement.....	16	12	0	4
Total	60	15	7	38

Table 2 shows the results that we have obtained in the treatment of these serious types of poliomyelitis in the Gallinger Municipal Hospital between July 1, 1938 and October 1, 1945.

(Continued on page 530)

President's Page

THE FUTURE IS IN OUR HANDS

Recently I have been reading "Personal Reminiscences" by Dr. Samuel Busey, who lived and practiced medicine in Washington through the period of the Civil War. It is delightful reading. For a time Dr. Busey boarded in the same house with Abraham Lincoln when he was a member of the House of Representatives. His description of Lincoln telling stories was so vivid and real that it was as though one had actually been present. As time passed Lincoln became President of the United States, and Dr. Busey, President of the Medical Society of the District of Columbia.

The practice of medicine in Dr. Busey's day was much as described in "A Doctor of the Old School." Hospitals as we know them were just coming into existence. Medical practice, too, was gradually rising to a higher level.

Following the Civil War there were difficult times not unlike those we are passing through today. There was a shortage of physicians, a shortage of help, inflation, and real problems of reconversion.

Since that time we have gained tremendously in knowledge of physiology, pathology, and the treatment of disease. We have more exact methods of diagnosis. But all of this has increased the cost of medical care. It is this which is one of our chief problems at the present time. How can we supply the best medical care within the ability of patients of moderate means to pay?

There have been plans for prepaid medical care which have proven satisfactory in other parts of the country to patients and physicians alike. Several committees have been working on this problem here in our Society and we hope to present a program of our own before many weeks pass.

I would like to emphasize how important it is that we have a definite program. If we do not offer a workable program almost surely the Government will insist on one of its own making, which I feel would be very undesirable.

Wm. Earl Clark

TO MEMBERS OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA:

The time has again come when the District of Columbia War Finance Committee must ask you for help. The Victory Loan will be in many respects a cornerstone of the peace. This Loan will give meaning and purpose to the victory. In a very real sense it will light the way to those horizons, the vision of which sustained our people during the dark, bloody days of the war.

The number one job facing our country today is to provide adequate medical care and hospitalization for our wounded heroes. At last count there were almost 500,000 of these men and women in American Army and Navy hospitals. To give these men the professional care and the tender attention they so richly deserve will involve the expenditure of hundreds of millions of dollars. It is little enough that our money can do for those who did so much for us.

Another task is to demobilize millions in the armed services and to assist these men and women in adjusting themselves to civilian life. There are certain specified benefits accruing to veterans under the law which will require additional hundreds of millions to finance.

We must continue to keep our armies of occupation in the field. To do so will require additional hundreds of millions of dollars. It costs almost as much to keep a soldier or sailor on active duty during the peace as during the war. Our people are of accord in voicing the determination that our Armed Forces at home and abroad must be provided with every facility they need to do the job at hand.

And, of course, you are well informed on the value of Victory Bonds as an able fighter against the ravages of run-away inflation. We must keep our economy intact. On its soundness rests the security of our democratic way of life.

We will be exploring a new field in selling Victory Bonds on such a large scale in a reconversion period. It is indicated, now that the war is over, that we may expect to find a lack of public understanding of the importance of this campaign. Because of this, and other reasons, I urge you to exert every effort in support of our campaign.

Your assistance in the past has been of immeasurable value. Under the able chairmanship of Dr. W. Calhoun Stirling your coöperation has been magnificent. Your War Bond Committee has been a real wheel-horse. It has doggedly pulled the load until the goal was reached—and exceeded. Every member of that committee has discharged his responsibilities with personal distinction.

The following members of the Committee will serve during the forthcoming drive: Drs. John U. Schwarzmamm, Edgar A. Bocock, Francis J. Eisenman, William J. Cusack, Edgar E. Quayle, Leo B. Gaffney, John M. Orem, Colonel N. L. McDiarmid, J. G. Capossela, Theodore Wiprud, Mrs. Elizabeth Rogers, Miss Mattie M. Gibson, Deaconess Margaret Bechtol, Mrs. A. Magruder MacDonald and Miss Tommie Bolton.

Your quota for the Victory Loan is \$1,250,000. This is identical with that assumed by the Medical Division in the Seventh War Loan. However, the job must be done in two instead of three months, the accounting period extending from October 29 through December 31. Dr. Stirling and his committee face a tough job. That they will exert the effort needed to do the job our Committee has the fullest confidence. But, they cannot do it alone. They need all-out coöperation and maximum Victory Bond buying from every member of the District Medical Society.

Give them that coöperation and they will enscribe the records of your Society with its most glorious chapter in its long record of patriotic service.

Yours sincerely,

W. J. WALLER
Chairman, D. C. War Finance Committee

Editorials

EDUCATION OF TOMORROW'S PHYSICIAN*

A survey of the problems facing medicine today has led to the recognition of two principles essential to the solution of the perplexing question of the distribution of medical care. First, the increasing knowledge and use of technical procedures in the recognition and treatment of disease have produced a considerable increase in the costs of illness. To a part of the American people, particularly those in the low- and middle-income groups, the costs of severe, unexpected, or protracted illness result in severe hardship and may bring financial disaster. Deserving of the best medical care that can be provided, these families are not eligible for the care of the indigent available in municipal institutions. The obvious method for spreading financial obligation over a number of years is through the principle of insurance. The first change, therefore, that one may expect is that medical care for a proportion of the population will be paid for on the basis of some form of prepayment.

Second, it is impossible for an individual physician to become expert in more than a limited segment of the field of medicine. It follows that the total care of the patient must inevitably become the responsibility of a group of physicians. The advantages of such co-operative service may, however, be offset by its increased cost to the patient. The development of a form of medical practice that will resolve these difficulties is a challenge which the new Medical Center of New York University will eagerly accept. As now visualized, it

would combine preventive and complete medical service by a coöperative professional staff, on a financial basis within the means of the individuals and groups to be served.

The medical school has a special role to fill toward the development of standards of medical care. Widespread reorganization is unlikely to be successful without preliminary exploration by local groups with adequate safeguards for the quality of medical care. For such experiments the medical schools are admirably qualified. They must continue to serve as the channel through which new knowledge passes to the general use of all physicians engaged in the care of the Nation's health.

Simultaneously with the requirement that physicians be thoroughly grounded in the physical and biological sciences has come the demand that he accept increased social responsibility. With sociology itself maintaining an academic or, at the best, a collective view of social problems, medicine has become the chief agency through which social science is applied. It is on the body of knowledge encompassed by medicine that some of the most important decisions in relation to social policy must be made. Pressing social problems find the physician largely unprepared and without the background of knowledge on which to recommend or act. The education of the physician of tomorrow can scarcely be considered complete without a knowledge of the medical needs of the people, probable costs, and the various means by which the costs can be defrayed.

The medical student needs further a background of the greatness of the history of his own profession, so that he may have a faith in its future. He needs insight into his position in

*This is the first in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

society, the aims of his profession, its hopes and problems. He needs to know how he may best fit into the world he is to face. He needs to be an educated man in order to enjoy the respect which will make possible the most effective use of his medical knowledge. These aspects of the medical student's preparation for life are now all but lost sight of, the students being allowed to learn these things by hard experience or not at all.

To establish these several ends there should be some intellectual or spiritual center for a medical school. It should have several purposes: first, the interpretation of the history

of medicine, with particular regard to the relation of the profession to society; second, the guidance of the medical student, so that he will learn to respect his profession's past and to dedicate himself to its future; and, third, the continued education of the practising physician in the area of the school so that, in the press of earning a living, he will not lose sight of the great aims of his profession. It is to these special aims of medical education that the proposed Department of the Humanities in Relation to Medicine will be devoted.

DONAL SHEEHAN, M.D.

Acting Dean, New York University School of Medicine

REHABILITATION*

For many years the attention of the medical profession has been focused on the diagnosis and treatment of disease and injury. During the last decade or two, a great deal of study and effort have also been devoted to preventive medicine. During the war, due mainly to the efforts of the Army and Navy, the medical outlook has broadened to include the third phase of medical care, convalescent rehabilitation. By this term is meant the employment of all available resources to speed the patient's convalescence and to restore him as rapidly as possible to his proper place in the family, community, and nation. Too often the fact that the patient is a person is lost in the complexities of diagnosis and treatment of specific disease and injury. This new approach to medical therapy, convalescent rehabilitation, is the attainment of the long sought therapeutic goal of "treatment of the patient as a whole."

In order for convalescent rehabilitation to be successful, physicians must realize that as a therapeutic program, it must be prescribed and directed by physicians in accordance with the

individual patient's limitations and requirements. It should be composed of three main elements, physical rehabilitation, mental rehabilitation and recreation. These forms of therapy should begin as early as possible in the course of a bed patient's illness, whether in the hospital or in the home. Naturally, the features available to the patient confined to bed at home are necessarily limited. However, the hospital patient and ambulatory patient should have access to facilities, equipment and personnel which will make possible the presentation of a well balanced program designed to shorten the convalescent period, decrease the incidence of complications, and diminish the number of hospital readmissions.

Briefly, the main features of such a physical program are general calisthenics, special remedial exercises when required, and the use of occupational therapy and physical medicine modalities as indicated. The mental rehabilitation program is comprised of interviewing and counseling (both of a social service nature and along vocational and educational lines), orientation of the patient to his environment and disability, and presentation of features such as motion pictures to occupy his mind in a

*The opinions and views set forth in this article are those of the writer alone.

constructive fashion. The proper use of recreation as a therapeutic measure cannot be overlooked in a well balanced treatment program, both for the bed and ambulant patient.

The Baruch Committee on Physical Medicine, having studied the programs developed by the Army and Navy, believes that the objective of both civilian and military practice is the same, that is, the return of the patient to his normal environment as rapidly as possible. A subcommittee has been making a study of the adaptation of the Service Rehabilitation Program to civilian practice and has drawn up model organizational and functional flow charts in the hope that these might be of service in the development of Civilian Rehabilitation Centers all over the United States. A great deal of interest has been displayed by other civilian organizations in this new medical development which has such far-reaching economic and sociologic implications.

The War Manpower Commission estimates that there are 23 million persons in the United States who, through injury, disease, maladjustment, or from their experiences in former wars, are in need of physical or functional rehabilitation, or both.

The opportunity has been presented to the medical profession to assume the lead in developing a program which not only appeals to professional reason, but to the common sense of the average layman. It would be most unfortunate if the medical profession should permit outside agencies to sponsor the development of such a program, which, by its nature, should be of primary interest to the profession.

MAJOR HENRY B. GWYNN, M.C., A.U.S.

*Reconditioning Consultants Division,
Office of the Surgeon General*

A MEDICAL OFFICER COMES HOME

Two Australian officers were guests at our hospital mess in the Northern Territory of Australia one evening in 1943. Inevitably the conversation turned to life in the United States and soon one of them commented, "The greatest trouble with you Americans is that you do not know how to enjoy life; you are so busy making money you never find out how to relax." It was an argument I had heard before and I had an answer ready. "Quite true; but isn't it a good thing that the people of some country besides Germany have been ambitious in the past twenty years?" Since no Australian ever had an answer to that one, we turned the conversation to sports.

It was many months later that I was riding the Overland Limited from San Francisco to Chicago coming home after more than two years in the Southwest Pacific Area. I had read seventeen books during the twenty-four days aboard ship between Manila and San Francisco,

but just looking at the countryside across the dear old U. S. A. was such an inspiration that I managed to read only three short articles in the *Reader's Digest* while aboard train. One of these was entitled, "Five Things We Can Learn from South America." The gist of the article was the same as the Australian officer's comment: We should learn leisure; we should learn to put things off until the next day, etc., etc. And again I wondered who would have stopped the Nazis and the Nips if the United States had spent the last hundred years relaxing in the South American way.

Even so, in the three months I have been home I have been impressed with the fact that so few people here seem happy or to be enjoying life. Not only does this seem noticeable in the little things of life such as the service we receive from surly clerks, sneering waiters and impatient street car conductors, but particularly so in the major matters of human relationship, where I

learn of acquaintances formerly very much in love who are now separated or living together only for appearance's sake.

A soldier overseas has difficulty comprehending this attitude. He feels that if he could only get home, the sheer joy of again being "Stateside" would so eclipse all else that nothing would ever again make him unhappy.

I think most Americans are suffering from a "prima donna complex." Each person believes himself 100 per cent correct and feels that no disagreement with his own views can be countenanced. If such a disagreement should be ventured, a thoughtful discussion is not to be tolerated lest one lose face. The original premise must be upheld with vigor rather than logic, with force rather than consideration, with

rancor and insult rather than courtesy and humor. And the inevitable result is tension, anxiety, bitterness, and finally death, if not physical, then spiritual and emotional.

I wonder if it is not possible to strike a balance in life. Cannot we Americans work hard but still retain a sense of humor; cannot we think deeply yet still reason wisely and accept suggestions graciously? No man who has been overseas doubts that our country is the most powerful in the world. Should we not also be able to make our people the happiest in the world, and the most contented with life? I believe we can. And I believe that we physicians can do much toward promoting such a life—both by precept and by example.

DARRELL C. CRAIN, M.D.

In and Out of Focus

BY THE OBSERVER

Has Change Come to the A.M.A.?

When your Observer journeyed to Chicago late in October to attend the Public Relations Conference sponsored by the American Medical Association's Council on Medical Service and Public Relations, he was in none too optimistic frame of mind. Nothing he had heard led him to believe that this meeting would be any different from others held in the Association's headquarters. However, it promised to be unique in at least one respect. Round table discussions had been planned for the first day of the Conference instead of the usual formal addresses. Subjects to be discussed were: Health Legislation, Extension of E.M.I.C. Program, The Public Relations Job, Placement of Medical Officers, Prepaid Medical Insurance Plans, Rural Health Problems, Activating Fourteen Point Construc-

tive Program for Medical Care, and Veterans' Administration Plans. The second day was to be devoted to formal reports from the moderators.

This arrangement, your Observer concluded, would at least permit free and unhampered discussion. But he doubted if it would lead to anything specific. The two-day session would undoubtedly close with no real progress having been made.

This time your Observer was due for a real surprise. It came first of all when Dr. E. J. McCormick, of Toledo, Chairman of the Council and presiding officer, announced that this meeting was going to be different. He said that round table discussions had been planned so that all participants would have an opportunity of saying just what was on their minds. He urged them to "take down their hair." Those present responded vigorously to this sug-

gestion. Enthusiasm missing at the usual meetings of this sort was much in evidence.

The Medical Society of the District of Columbia was represented at the Conference by Dr. Joseph S. Wall, who was present in a dual capacity, appearing on behalf of the American Academy of Pediatrics of which he is President and of the Society's Committee on Public Policy of which he is Chairman, Dr. Herbert P. Ramsey and your Observer. Dr. Wall gave a splendid account of himself. In fact, his discussion of the extension of the E.M.I.C. program was so highly thought of that it will be published in an early issue of the *Journal of the American Medical Association*. Dr. Ramsey set forth the Society's viewpoint on many important matters under discussion, particularly legislation. Your Observer was an active participant in the round table on public relations.

The most surprising development at this meeting was the unanimity of opinion expressed in various reports as to the course that the American Medical Association should pursue. Without dissent all agreed that the negative approach could no longer be justified, that a positive stand was called for and that public support could only be obtained if the medical profession offered a constructive health program. Platforms and principles, it was clear, were not sufficient. A blueprint of a specific program was needed.

This change in attitude was reflected in the report presented by Dr. John H. Fitzgibbon, of Oregon, moderator of the round table discussion on public relations. Dr. Fitzgibbon had appointed a committee, of which your Observer was a member, to draft the report, which read in part as follows:

"In understanding the public relations effort of medicine, the committee would call attention to the fact that it is now generally recognized that the relations of the individual physician to the individual patient in the United States are on a substantially sound basis. In other words, the public does not express, in general, resentment against the individual physician.

The surveys seem to have shown that the public acceptance of the American Medical Association and its policies is favorable so far as concerns scientific progress, health education and protection of the public against inferior medicine and quackery. Antagonism of the public toward organized medicine seems to rest on the basis that the opponents of organized medicine offer a specific program which promises complete medical care on what seems to be a relatively small financial outlay, whereas the medical profession has not yet come forward with a specific program for the extension of medical service on a nation-wide basis with a system of payment easily available and sufficiently attractive to insure early enrollment of at least 50 per cent of the public. The task of public relations would be rendered much easier if those concerned could be put in possession of a constructive program which they could promote to the public rather than in a position of continuous defense against programs coming from other sources."

It should be kept in mind that neither the round table groups nor the Conference in full assembly had power to act. They could only adopt recommendations, which they did. These will be presented to the House of Delegates of the American Medical Association. What the House does with them will determine whether those attending the Conference witnessed the beginning of a new era in organized medicine. In your Observer's opinion, failure of the House to support the Council's recommendation to formulate a national health program will be cause for deep concern and may have tragic consequences.



*Good Medical
Care for
Veterans* Controversy over the inadequacy of medical care for veterans became so acute a few months ago that a drastic overhauling of the administrative machinery of the Veterans Administration was inevitable. The appointment of General Omar M. Bradley, one of the Army's ablest officers, as Administrator was hailed everywhere with approval. His choice of Major General Paul R. Hawley as Acting Surgeon General of the Administration was equally well received. General Hawley

wasted no time in making it clear that veterans will receive the best medical care. As he well knew, this will be possible only if he is able to obtain the services of top-flight physicians. Considering past history, this would not be easily accomplished. Satisfactory conditions under which to practice and fair compensation for services rendered were essential to attract men he desired. General Hawley was determined to hurdle these obstacles. He got off to a good start when he obtained Dr. Paul B. Magnuson, of Chicago, a highly regarded orthopedic surgeon, to develop a research and post-graduate program in veterans hospitals. Others equally qualified in their respective fields, it is expected, will soon join Dr. Magnuson.

In addition to improving the quality of the Administration's medical staff, General Hawley proposes that those veterans who cannot for one reason or another be taken care of at the Administration's facilities and must of necessity go to private physicians shall also receive good medical service. With this in mind he has conferred with officials of the American Medical Association and several medical societies, among them our Society, to determine the basis on which such service can be provided. Before this is published a plan for the care of veterans by private physicians in the District will undoubtedly have been submitted to General Hawley. The plan, developed by the Society's Committee on Industrial Medicine, contemplates the establishment of a clinic manned by members of the Society in various specialties volunteering to examine veterans for pensions.

There is already a backlog of more than 1,000 veterans seeking pensions who are waiting to be examined. Only 15 a day are being taken care of by the present depleted medical staff at the regional office of the Administration in Washington. The situation is expected to grow more serious as the number of returning veterans increases. Obviously something must be done without further delay.

It was thought that volunteers for service in

the clinic might be compensated on an hourly basis, but General Hawley informed the Society civil service rules would not permit. A fee schedule was therefore submitted with the approval of the Society's Executive Board. As examinations alone are contemplated, the schedule was prepared in a matter of only a few days.

At the same time the Committee began work on a schedule of fees for treatment of veterans in physicians' offices. This schedule has also been completed and forwarded to General Hawley. However, if acceptable to him, it must still be approved by the Executive Board. At its meeting on October 22 the Society's Executive Board created a Committee on Medical Care for Veterans. As its name implies, this Committee will concern itself with all matters relating to the health of veterans. Its coöperation will undoubtedly be welcomed by the Veterans Administration and veterans organizations.

Your Observer is confident that every physician who agrees to treat veterans will give them the best care of which he is capable and that there never will be cause for complaint on this score.



Group Practice and the General Practitioner Desirable features of group practice have been the subject of wide discussion in the last year or two. With much of what has been said your Observer concurs. However, he recognizes that there are practical difficulties in the path of those who venture into this field. This is especially true in urban centers where irreparable cleavages in the medical profession may result. Naturally not all physicians in the community can affiliate themselves with groups. How, then, can group practice be carried on in our large cities without arousing professional antagonisms?

Some sound observations are made by *New York Medicine* in its October 5 issue. Prin-

ciples governing group practice, the journal points out, still remain to be defined, but it offers for consideration certain basic principles.

"First, as a general principle it seems to us that the fundamental objective of all desirable medical reform should be to enable the general practitioner to practice good modern medicine at the lowest possible cost to his patients. Specialism has, we believe, justified itself. Certainly it requires no further argument on the part of the editors of *New York Medicine* to establish the specialist in our present scheme of things. On the other hand, we submit that the family physician, the general practitioner, is and will continue to be the keystone of medical practice. He is needed as the coördinating unit of the various specialties and he is as essential to the medical team as the infantryman is to the military.

"Therefore, the proper direction for the practice of medicine to take is one that will encourage and assist the general practitioner in fulfilling his all important function in the care of the patient. Conversely, it follows that any new plan of medical service which would appear to segregate and seal off a segment or segments of the population under the sole responsibility of a group of specialists, breaking off the usual contacts between these patients and their specialists on the one hand, and the general practitioners of the community on the other hand, is antithetical to good medical progress.

"Accordingly, medical groups engaging in what is called group practice should seek to correlate their services with those of the general practitioners in the community and should aim to help them practice the best kind of modern medicine, by making diagnostic assistance and consultation more easily, more economically available to them and their patients."

Relationship of the patient to the specialist, the journal points out, is usually of a temporary nature. The patient cannot look to a group of specialists for continued care. He will, therefore, require the services of a general practitioner "for guidance as to which specialists he needs, for interpretation of their findings in terms of his general welfare, and for a final decision as to what should or should not be done to implement all the suggestions that may be made to him by various consultants encountered during the course of his medical experiences." The general practitioner will continue to be the one on whom the patient must rely for his medical care and for his sake "any plan or

group practice must have as its first objective the assisting of the general practitioner to provide the best care that medical science can offer him."

In all this your Observer most heartily concurs. Certainly group practice will not succeed if the medical profession is divided as to its desirability. In fact, without wise leadership it may be the cause of unending strife within medical ranks, thereby depriving the people of the best medicine has to offer.



Editors of popular magazines "*Physician, Heal Thyself*," are constantly seeking material which will increase the circulation of their publications. Public taste fluctuates and it is their business to detect trends. For some time there has been a growing interest in medicine. Most magazines of a general nature feature at least one or more so-called health articles a year. Contributors usually have either scientific background or the professional qualifications to deal with their subjects. Unfortunately, this is not always so. There are incompetents in this field as in every other. Then, too, there are writers who, knowing better, sensationalize their material with the result that it is misleading. Generally speaking, however, an honest and intelligent presentation is made.

There is no subject which intrigues the layman more than health habits which are conducive to longevity. Therefore, one sees many articles on this subject. Some weeks ago your Observer ran across an article in *This Week*, a syndicated magazine supplement to Sunday newspapers. It was entitled "Who'll Live Longest?" and was written by Helen C. Bennett. Miss Bennett had apparently delved rather deeply into the statistical material available on her subject. Among other things she says, "If your object in life is to outlive other people, don't be a doctor. Their expectancy is less than that of almost any other profession.

It's a grim fact that physicians, who have done most to extend the lease on life for humanity in general, have been among those least benefited by the extension."

Now there is nothing startlingly new about this statement because the mortality rate among doctors of middle age has been notoriously high. Physicians have become familiar with the lengthy obituary lists in the *Journal of the American Medical Association*. They know, too, that a majority of physicians die from heart failure. One would think that in the face of this knowledge physicians would do something about it. But it appears that for one reason or another they ignore the whole business.

What is wrong with doctors where their health is concerned? Why do they fail to apply preventive measures with which they are so familiar? Why are they so inclined to break every health rule? Only physicians themselves know the real answers to these questions.

As custodians of the health of their patients, physicians insist upon compliance with their instructions. Plenty of rest, no tobacco and very moderate use of alcoholic beverages mean just that. But how frequently they neglect to apply such prohibitions to themselves. As for a health inventory, it never occurs to most of them. Whether this indifference to their own health is due to a feeling that physicians are exempted from mortal ills, your Observer does not know. What is apparent is that most doctors seem determined not to be concerned about their physical or mental well-being.

It is high time that something be done about this situation. For this country can ill afford to lose doctors in what should be the prime of life. Laudable steps have been taken to make people conscious of diseases that can be prevented. We have become familiar with Cancer Month, the Christmas Seal Campaign, and the President's Birthday. In view of the great need for physicians in this country, efforts to save the lives of those who neglect themselves to the extent that they die before they should might be

undertaken. Perhaps what we need to make doctors more conscious of their own health is a Doctors Health Month. It might prove more than a little embarrassing; on the other hand it would perhaps bring results, which after all is what counts.

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"...Fear Is a
Poison..."

"The prospect of summoning a doctor, for himself or for one of his family, frightens almost every layman. This may be—and doubtless is—absurd; but the fear is deeply rooted in the past—and the physician himself is its father."

Thus Ben Ames Williams, American novelist, sounds the keynote of a George W. Gay Lecture on Medical Ethics, given at Harvard Medical School in May of this year and published in the October 11 issue of the *New England Journal of Medicine* under the title "The Greeks Had a Word for It."

"Among the lesser deities worshipped by the ancient Greeks," Mr. Williams writes, "there was one who wore the beard, the ears and the horns of a goat. In fact, his imaginary aspect largely shaped our subsequent conception of the Devil. According to the Greeks, when this creature appeared suddenly to human beings, he awoke in them a storm of sudden fear. They called him Pan, and called the fear that he evoked 'panic.'"

"In this respect, in this trait of provoking panic or fear, the great god Pan has his prototype today; but we no longer worship the lesser gods, so we do not call him Pan. We call him 'Doctor,' and tremble at his name."

Mr. Williams believes that too many doctors are oblivious to the devastating effect of thoughtless behavior on patients.

"Fear is a poison, yet sometimes doctors seem deliberately to provoke fear. It is as though they were completely unaware of the impact on a patient of their smallest word. A certain doctor, while making a routine examination of a patient who had come for a simple checkup, applied the stethoscope and listened

for a moment and then asked gravely, 'Has anyone ever told you you had heart trouble?' The patient, naturally startled, said: 'No. Have I?' The doctor, without replying, turned and left the room. That was a dozen years ago, and no doctor has yet discovered that there is anything wrong with the patient's heart; but the idiotic question left behind it a cloud of shadowy terror that only time dispelled."

What can the doctor do to alleviate this fear? Mr. Williams offers these suggestions:

"In a large proportion of cases, the good that the doctor can do the patient is determined within a few minutes after their first meeting. If you are to free the patient of his fear of you, if you are to win his confidence and if you are to enlist his coöperation, these first moments are vital. Mistakes made then are hard to remedy. The most successful doctor is the one who supplements his professional competence with what salesmen call a good approach. For before a doctor can do his best, he must sell himself to the patient, must lead the patient into such a mental attitude that he will get well to please his doctor—or to disappoint him. Tell one man he is going to die; he may retort, 'I'll be damned if I do' and proceed to prove you wrong. And the reverse may sometimes be true. . . ."

"As a newspaper reporter sent to interview celebrities I used to try to learn in advance something about them—and about their particular field of work—that they themselves did not know. If you can know your patient better than he knows himself,—not only physically but psychologically,—you are so much the better equipped to help him.

"After you have made his acquaintance and have soothed his fears, you will already have begun, by observation, your diagnosis. If you have made a good beginning with him, he will by this time be eager to help you. Phrase your questions in such a way that you seem to expect certain answers—and do this particularly when the answer you seem to expect is not significant. If he then gives you an opposite answer, you may accept it as true; for he gave it reluctantly, believing that you expected an opposite reply and regretting that he must disappoint you. But no matter how alarming his answers to your questions may be, you should always appear to find them reassuring; for the most dangerous drug you can administer to your patient is fear.

"When you reach the stage of prescribing treatment, your first care should be to avoid reawakening the fear that you have sought to relieve. As for treatment, never forget that the patient, like the customer, is always right. This may not be literally true, but it is true in enough cases to make every wise physician

cautious. I remember a man who had been operated on for cancer of the rectum and who was thirsty and to whom water was forbidden. He took advantage of the nurse's momentary absence, got out of bed, walked down the corridor to the water cooler, drank all he wanted—and thereafter made an astonishingly swift recovery and never had another sick day until twenty-seven years afterward, when a runaway truck jammed him against a store front and crushed his spine—this in spite of the fact that he had had a disease that is ordinarily considered to be incurable.

"But that is beside the point. The point is that he drank a forbidden draft and got better. The point is that the patient often knows best what is good for him."

Mr. Williams' remarks were, of course, addressed to medical students. But they should have more than passing interest to physicians of experience. Too often they become calloused or indifferent to the emotional reactions of patients. This undoubtedly accounts in a measure for the failure of some patients to respond to sound therapy.

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Dangerous Barbiturates? Your Observer has already commented on the growing public interest in medicine as shown by numerous articles on various phases of the subject appearing in popular magazines. Perhaps the best articles of this type have appeared in *The American Mercury*. They have on the whole been written by competent authors, most of them physicians. In the October *Mercury* Dr. Theodore G. Klumpp, formerly Director of the Division of Drugs, Food and Physical Therapy of the American Medical Association, writes on the subject "Sleep and Sleeping Pills." Although most of what he has to say is elementary to physicians, his comments on the use of barbiturates will, your Observer believes, be of interest to them if for no other reason than the fact they were written for public consumption. Dr. Klumpp writes:

"During recent months the question of the safety of sleeping pills has been brought before the public. The case against sleeping pills may be summarized as follows:

1. Sleeping pills are dangerous drugs and as such are too easy to obtain.
2. The number of suicides and deaths from their accidental use is increasing.
3. Sleeping pills are habit-forming and under their influence abhorrent crimes are being committed.

"Let us consider these points. According to official statistics over 5,000,000 ounces of the barbiturates were sold in 1940 in the United States. This amounts to over one and one-half billion doses of sleeping pills, or approximately four and one-quarter million doses per day. There are reported 246 accidental deaths from barbiturates and 299 suicides during the same period. Regrettable as these deaths are, their number must be considered in relation to the total of 18,907 suicides of which 5,623 were by means of other poisons, 1,324 accidental deaths from other poisons, and 124,121 accidental deaths from all causes except motor vehicles. In further contrast, there were reported 5,260 deaths from alcohol in the same period, which is almost ten times the number of deaths from barbiturates. Moreover, it is conceded that the deaths from alcohol represent only approximately half of those that actually occurred, since physicians are generously willing to spare the relatives the stigma attached to a record of this cause of death.

"As a matter of fact, the barbiturates, even if taken in huge amounts, seldom do serious injury. Many epileptics, for example, have taken phenobarbital (Luminal) in daily amounts of from one to seven times the ordinary sedative dose for periods as long as thirty years—with inconsequential effect on the brain or nervous system. And ordinary individuals have survived after taking 108 times the therapeutic dose of one type of barbiturate, 52 times the therapeutic dose of another, and 90 times that of a third. Dr. R. D. Gillespie who made a study of the barbiturate literature stated that no case has been recorded in which either a single dose or repeated doses of average therapeutic size caused death in the absence of complicating factors."

"The barbiturates, like alcohol and tobacco, are capable of causing habit-formation when used steadily by those who are constitutionally unable to exercise normal self-control. However, Professor Sollmann expresses the accepted authoritative view on the subject in stating, 'There is no dangerous cumulation, and practically no habituation, no need for increase of dosage, and relatively small liability of addiction, none beyond that entailed by the desire for easy sleep.'"

Dr. Klumpp is careful to point out the mental causes of insomnia and how they may often be ameliorated without resorting to drugs.

New Zealand's Medical Troubles

Several months ago your Observer commented on New Zealand's difficulties with its free medical service. The rush for medical care plus the dearth of doctors had raised havoc. Then, too, physicians were charged with commercialism. One physician who had just returned from service with the armed forces described the situation as "an awful racket."

The increasing tempo of the war evidently diverted public attention and nothing more was heard about the matter. But apparently it was only a lull in the storm which has again broken over this country's system of medical care.

According to Quentin Pope of the *New York Times*, the New Zealand government is seriously considering whether it will continue its "free physician service." The government admits widespread racketeering which followed the institution of a system under which any New Zealander may consult any physician as frequently as he likes and the doctor can collect a fee for each visit. The National Medical Council has endeavored to have the Health Ministry act to control what it holds to be an unwarranted drain on the social security fund.

"It has been revealed," Mr. Pope says, "that, though many doctors are still in the armed forces, payments to doctors have been 50 per cent higher than the \$5,000,000 a year that the Government calculated would cover the total annual peacetime cost of medical care.

"Moreover, the increasing annual cost of medicines has been alarming the Health Department for the last three years. In addition, figures relating to the cost of medical care previously published by the Health Department have been suppressed for the past two years.

"The National Medical Council, which has listed numerous abuses, including 'overconsultation,' the speedy examinations of patients, some at rates of twelve an hour, payment of \$6,000 a year for one afternoon's work and the charging of a fee for each patient seen on visits to institutions for the aged and the invalid, has been attempting to persuade the Health Ministry to curb these practices."

Government leaders declare that the present income taxes, which are as high as seven-eighths

of the earnings of citizens, "enable the Government to recover most of the money paid to such doctors." The Health Ministry, however, is charged with having concealed the doctors' high earnings from Parliament, revealing only sums paid from the social security fund to unnamed individuals and ignoring the fact that under the present system patients must meet at least three-tenths of the cost of each consultation.

Mr. Pope observes that in the beginning the government endeavored to employ physicians on an annual fee basis for each patient, and eventually hopes to put doctors on a fixed income. "Parliamentarians," he says, "emphasize that since free medical care began New Zealand has created the biggest hospitalization setup in the world."



*Sorry, but
It's Too Late* One of the things which galled the defendants in the Group Health case was the fact that a criminal charge was brought against them. If they had been hailed into civil court there would not have been the stigma attached to being prosecuted as ordinary lawbreakers. At least this was the attitude of some of those who were defending themselves against the charge of criminal conspiracy.

It appears now that the criminal indictment of organized medicine was pretty much of an accident. At least this was the impression gained by your Observer as he listened to affable Attorney General Tom C. Clark address the Washington Rotary Club a few weeks ago. Mr. Clark said that the Justice Department's program of bringing criminal prosecutions under the antitrust laws has been changed to cover certain circumstances. Such prosecutions, he said, will not be brought in violations involving certain established trade practices as distinct from outright price fixing.

The Attorney General extended an invitation to businessmen and their attorneys to come to the Justice Department to discuss matters re-

lating to antitrust policy. "I don't mean that we'll necessarily give you a clean bill of health," he said, "but we will tell you of any kinks that exist in the practices you intend to follow."

To which physicians might respond, "Well, Tom, we wished you had come along five years earlier." For, as will be recalled, the Department did not offer the Medical Society of the District of Columbia an opportunity to eliminate "kinks" in its practices before an indictment was sought. Perhaps there is no point in saying anything about this now. After all the clock cannot be turned back, nor will the new policy of the Department of Justice make any difference to organized medicine. However, it is interesting to speculate how men in high places affect the lives of organizations and individuals. In this instance it seems the defendants in the Group Health case would have fared better at a later date.



New Classification Committee

The complaint is often heard that in most large cities in this country there is no reliable source of information about physicians. Whether this criticism be justified your Observer is not prepared to say. If it is true, Washington is an exception to the rule. For the Society's telephone exchange, MEDICAL BUREAU, has long had a classified list of physicians at its disposal. Data supplied about each physician include his specialty, if any, hospital affiliations, location and office hours. Those listed as specialists must be privileged to practice their specialties in Class A hospitals. General practitioners have been subdivided into districts for the convenience of inquirers.

Physicians who have seen the list have found little fault with it. However, the Society's Executive Board has taken the position that it can be improved upon. It was this that prompted the creation of the new Classification Committee. This Committee will review what has previously been done and will develop its own methods of classification subject, of course,

to the approval of the Board and the Society itself.

Classification of physicians is something which cannot be undertaken lightly because the public has a right to expect that it will be carefully done. Failing in this the Medical Society would rightly forfeit its confidence.

Which reminds your Observer that the American Medical Directory, valuable though it is, is often misleading where specialists are concerned. In the past it has been the physician who determined whether or not he should be listed as a specialist. Often he has no special qualifications nor does he limit his practice to the specialty claimed. This should be corrected in future directories. Until membership in a specialty board is a requisite, it might be accomplished with the cooperation of state and county medical societies.

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"Lost Generation of Physicians" Medical educators are frank in saying that training of medical students during the war has been superficial and incomplete. They have been particularly perturbed because of the inadequacy of training during internship. They have decried the reduction in the number of interns who have been permitted to take residencies, making the point that the ground lost can never be regained.

Recently Dr. George Baehr, Director of Clinical Research at Mount Sinai Hospital in New York, again warned that unless steps are taken to remedy the situation this country may find itself with a "lost generation of physicians." Dr. Baehr emphasized the point that poorly balanced medical training was the root of the trouble and unless hospitals are able to increase their training facilities newly graduated doctors as well as young doctors discharged from the Army and Navy will be inadequately equipped to provide the best type of medical service. He urged that additional hospital residencies and fellowships be established and more space

made available for training. The experience gained in the Army, he observed, is not comparable to the hospital training in peacetime. He believed that hospitals could readily make room for young doctors who entered the armed forces after brief internships without hindering the careers of men and women now being graduated from medical schools.

Thoughtful leaders in medicine will wholeheartedly approve the sentiments expressed by Dr. Baehr. It behooves them not only to lend their vocal support but to act before it is too late. Our physicians in the armed forces are coming home in increasing numbers. In Washington as elsewhere they must be provided every opportunity to fit themselves for the exacting tasks which lie ahead.

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Postgraduate Course Scheduled There being no ANNUAL SCIENTIFIC ASSEMBLY this year, several special events have been planned or are under consideration. The first of these was the TROPICAL DISEASE SEMINAR conducted so successfully by the Program Committee. In this connection it should be generally known to our members that were it not for the tireless efforts of Dr. Oscar B. Hunter, Chairman of the Committee, the SEMINAR would not have been possible. Our Society already owes him a great deal more than it can ever repay.

Early in January of next year the Committee on Postgraduate Education will offer a POSTGRADUATE COURSE IN DIAGNOSIS. This course will be in addition to the one customarily sponsored by the Committee late in the spring. Subjects to be discussed by the ablest authorities in their respective fields are:

January 7—Acute Cardiorespiratory Conditions

January 14—Acute Vascular Accidents of the Extremities

January 21—Acute Abdomen

(Continued on page 530)

Washington Physicians of Yesterday



WILLIAM WARING JOHNSTON, M.D.

Dr. William Waring Johnston was one of Washington's most distinguished physicians in the latter 1880's. Close friend of Sir William Osler, he counted among his intimates leading scientists of the day. He was a successful practicing physician, having as his patients Cabinet officers, Justices of the Supreme Court and Senators.

Born in the District of Columbia on December 28, 1843, Dr. Johnston received his early education at St. James College, Baltimore. He was graduated from the University of Pennsylvania with the degree of Doctor of Medicine in 1865. After his graduation he served an internship at Bellevue Hospital, New York. Postgraduate study followed at the University of Edinburgh and in Paris hospitals.

In 1871 he became Professor of Theory and the Practice of Medicine at the Columbian Medical School (now George Washington University School of Medicine), a post which he held until his death. He was President of the Medical Association of the District of Columbia in 1888-89.

Dr. Johnston died at Atlantic City, New Jersey, on March 22, 1902.

THE 1945 DAVIDSON LECTURE

Biennially the Medical Society presents the Davidson Lecture, established in 1929 in commemoration of the outstanding service rendered to the medical profession in the District of Columbia by Dr. Edward Young Davidson. The papers presented by the lecturers have been of uniformly high standard. Selection of a lecturer was placed on a competitive basis in 1936. It was hoped that the Lecture would prove a stimulus to research and high performance not only among older and established practitioners but among the young physicians as well. It was accordingly agreed that "the selection of the Davidson lecturer will be on the basis of competition, the winning essay to be selected by a subcommittee consisting of five members of the Executive Board appointed by the Chairman..." The second Wednesday in October of the odd numbered years was fixed as a permanent date for these lectures.

The subcommittee of the Executive Board to make a selection of the lecturer this year were Dr. William Earl Clark, Chairman; Drs. Fred R. Sanderson, A. Magruder MacDonald, Cour- sen B. Conklin, and Henry R. Schreiber. Their choice was Dr. Joseph Thomas Roberts, who submitted a paper on "The Role of the Small Vessels and Nerves of the Heart in Heart Failure and Cardiac Pains." The subcommittee was impressed by the excellent manner in which Dr. Roberts presented his material and its originality.

Needless to say it is a distinction for a physician to receive the Davidson Lecture award. The subcommittee feels that Dr. Roberts was a most worthy choice.

Dr. Joseph Thomas Roberts has been Chief Medical Officer, Department of Medicine, Gallinger Municipal Hospital, since 1943, and Adjunct Clinical Professor of Medicine, George Washington University and Georgetown University Schools of Medicine during the same period.

Born in San Marcos, Texas, October 21, 1909, Dr. Roberts attended public schools in the town of his birth. He received his Bachelor of Arts degree from Southwest Texas Teachers College in 1929, his

Master of Science degree from Tulane University in 1933, and his degree in medicine from the latter institution in 1936. Following postgraduate study at Tulane, he received the degree of Doctor of Philosophy in 1941. Postgraduate study was pursued also at the University of Ohio, University of Pennsylvania Graduate Hospital, Western Reserve University, (Cleveland) and Harvard Medical School.

His specialty is internal medicine, being a diplomate of the American Board of Internal Medicine.

Dr. Roberts has held teaching appointments as Instructor in Gross and Microscopic Anatomy at



JOSEPH T. ROBERTS, M.D.

Tulane University, Rees Fellow at Western Reserve University, and as Assistant Professor of Anatomy and Medicine and Instructor in Pediatrics at the University of Texas.

Dr. Roberts is a member of many scientific societies, including the American Federation of Clinical Research, American Association for the Advancement of Science, American Association of University Professors, and the American College of Physicians, of which he is an Associate member.

He has contributed numerous articles to scientific publications, among them the *American Journal of Physiology*, *American Heart Journal*, and several state medical society journals.

Military Affairs

DR. DRAPER RECEIVES SERVICE AWARDS

Dr. Warren F. Draper resumed his former position as Deputy Surgeon General of the United States Public Health Service on October 2. From May 1944 to June 1945 he served in the Armed Forces of the United States with the rank of Major General. He was Chief of the Public Health Branch, G-5 Division, Supreme Headquarters, Allied Expeditionary Force. For his outstanding service he was awarded the Distinguished Service Medal. The citation for this medal reads: "He directed the formulation and execution of the Supreme Commander's policies governing public health in liberated nations and conquered territories. Drawing on his many years' experience, he coordinated all resources for the prevention and control of civilian epidemics which might have interfered with military operations, and successfully met tremendous problems caused by the chaotic conditions left by the war in many areas. The plans and procedures drawn up by General Draper were successful in every test. Through controlling disease in Europe, he contributed in the highest degree to the success of the Allied forces."

Dr. Draper was also made Honorary Companion of the Bath by the British Government. The citation covering this award stated that he was "responsible for the health of liberated countries of North West Europe and for occupied Germany. That the typhus in Germany has been kept under control, and that a good standard of health of liberated territories has been maintained is largely due to General Draper's marked ability, experience, tact, and the universal respect of epidemics and abnormal disease in the liberated territories will remain a lasting tribute to his work."

"General Draper's relations with the British medical authorities have been at all times cordial, and he has rendered through his advice and guidance great assistance to the British Forces."

Dr. Draper's many friends in Washington will not be surprised that these honors have come to him. For he distinguished himself in civil life as he has in the armed forces. Few able men are as modest about their accomplishments as Dr. Draper.

POSTGRADUATE COURSES AT GEORGE WASHINGTON

The plans for postgraduate instruction in the various fields of medical and surgical practice to be offered at the George Washington University School of Medicine are rapidly taking form. These courses are designed primarily for medical officers as they are released from the armed forces, but will be open to civilian physicians if vacancies remain after caring for the needs of the medical veterans.

The program is made possible through the generosity of the W. K. Kellogg Foundation of Battle Creek, Michigan. Charges will be made for all courses under the provisions of the "G. I. Bill of Rights." Thus no medical officer will incur any

personal expense while taking the courses, and will be eligible to receive subsistence allowances from the Veterans Administration while registered for courses.

A general review course will be offered for nine weeks beginning February 11, 1946. In this course all fields of medical practice will be presented in survey form, using outstanding guest physicians to supplement the medical faculty of the University. Much of the teaching will be accomplished by round table conferences, clinics and demonstrations. Recent advances in each field will be covered. This general review course should be of especial interest

to the general practitioner who is beginning or returning to practice. It will also be valuable for the younger physician who plans to pursue specialty training but wishes an over-all review before beginning his hospital service.

Short, intensive advanced courses will be available in Internal Medicine, Psychiatry and Neurology, Infectious Diseases, Pediatrics, Obstetrics and Gynecology, General Surgery, Public Health and Anesthesia. These courses will vary from one to six weeks in length. Instruction will be given in hospitals and dispensaries and will be accomplished by seminars, conferences, clinics, etc. Guest physicians will aid in the instruction in all courses. There will be opportunity for the examination of patients and for instruction in the technics of the specialties. Registration in these courses will be limited. These courses will be given at various times during February, March and April, 1946.

Longer graduate courses will be available in certain specialties. These courses will be designed

to give credit toward specialty board requirements. Registration in each course will be limited. Seminar methods of case study will be utilized. Selected cases will be assigned for individual work-up. These courses will begin as soon as a sufficient number of registrations have been received in each field.

Preceptorships in the various specialties are offered and a limited number of applications can be handled at the present time. These cover all the more common fields of specialty practice. Under this plan men who have already received training in a specialty will be offered temporary association with an established specialist. All specialists listed are certified by the appropriate specialty board. Application forms are available for those interested in preceptorships.

Information concerning any of these courses can be obtained from the Director of Postgraduate Instruction, George Washington University School of Medicine, 1335 H Street, N. W., Washington 5, D. C.

NAVY RETURNS V-12 STUDENTS TO INACTIVE DUTY

Approximately 8,500 students in the Navy V-12 Program pursuing medical, dental, theological, premedical, predental and pretheological training were returned to inactive duty on November 1. The remaining 25,500 students in the Navy V-12 Program will either graduate or continue their training in college as apprentice seamen on active duty. Final disposition of all students in the program will be made by June, 1946.

As previously announced, V-12 training at 69 of the 124 colleges and universities throughout the country with V-12 and NROTC units terminated on November 1. Training will continue at 42 NROTC units and 13 V-12 units in the program and at 10 newly established NROTC units.

Approximately 5,700 medical and 1,450 dental students will remain on active duty until the end of the semester now current or starting before November 1. Another 1,500 V-12 students entering medical or dental school this fall will remain on active duty for one term. Medical and dental students will be returned to inactive duty as enlisted men and will subsequently receive probationary commissions in the Naval Reserve and be retained on inactive duty.

A total of 250 theological and 95 pretheological students were returned to inactive duty as enlisted men at the end of the academic term now current or starting before November 1. Later those eligible will receive probationary commissions as ensigns in the Naval Reserve and be retained on inactive duty.

There are 1,056 premedical and predental students in the program who were returned to inactive duty as apprentice seamen at the end of the current academic term on November 1.

V-12 trainees who were scheduled to be enrolled in the NROTC on or before November 1, 1945, will be retained under instruction on active duty until June, 1946, unless they become eligible for commissions or discharge from the service at an earlier date. Students specializing in engineering continued their training after November 1 in the Navy V-12 Program as scheduled. Marine Corps students in the V-12 Program continued their training after November 1.

Students in the Naval Aviation Preparatory Program who were scheduled to enter the program on or before November 1, 1945, were retained under instruction on active duty.

News and Personals

A **Tropical Disease Seminar** was presented at the Medical Society's building on October 28. The Seminar opened at 10:00 a.m. with introductory remarks by Dr. Oscar B. Hunter, Chairman of the Program Committee, and greetings from Dr. Wm. Earl Clark, President of the Society. Colonel J. E. Ash, of the Army Medical Museum, was the Moderator.

Following is a list of the speakers and their subjects: Brigadier General George R. Callender, Assistant Commandant, Army Medical School, "Dysenteries and Tropical Diarrheas"; Colonel Ash, Director, Army Institute of Pathology, "Leprosy"; Major Arthur C. Allen, Pathologist, Army Institute of Pathology, "Rickettsial Diseases"; Lt. Colonel Balduin Lucké, Deputy Director, Army Institute of Pathology, "Epidemic Hepatitis"; Sophie Spitz, M.D., Pathologist, Army Institute of Pathology, "Malaria; Blackwater Fever"; Major Clarence C. Livingood, Consultant in Dermatology, Surgeon General's Office, "Tropical Dermatoses"; Sophie Spitz, M.D., "Schistosomiasis; Filariasis"; Colonel Ash, "Treponematoses."

The Seminar, which lasted throughout the day, was enthusiastically received by the 167 members and guests who were in attendance.

The Fifth Annual Physicians' Golf Tournament, sponsored by the Medical Society's Sports Committee, was held at Burning Tree Country Club, October 25. Despite inclement weather 27 golfers were on hand for the tournament. They played most of the time in the rain.

Winners in the tournament follow. Low Net: Drs. Allen Lloyd, Herbert H. Diamond, H. Franklin Kreuzberg, Joseph V. Kennedy, Arthur B. Little; Low Gross: Drs. Joseph P. Kendricks, Howard L. Smith, Frank M. Hand, Hayden Kirby-Smith, E. J. Cummings, Paul S. Putzki. Other prizes were awarded Drs. James P. Kane, Millard F. Ottman, William C. Sparks, James Hawfield, Clayton Hawfield, Jeter C. Bradley, Leo B. Gaffney, Robert J.

CALENDAR OF MEETINGS

October 2	Board of Censors
October 9	Committee on Industrial Medicine House Committee Section on Pathology and Laboratory Medicine
October 10	Scientific Meeting of Society
October 12	Committee on Sports
October 15	Committee on Postgraduate Education
October 17	Scientific Meeting of Society
October 18	Committee on Service Physicians
October 19	Committee on Industrial Medicine
October 22	Executive Board
October 24	Scientific Meeting of Society
October 26	Grievance Committee
October 28	Tropical Disease Seminar
October 31	Scientific Meeting of Society

Coffey, J. M. Gaines, Alan J. Chenery, Mario Scandiffio, and Messrs. H. P. Underwood, Wm. H. Mylander, R. I. Lyon, and Theodore Wiprud.

The following firms donated prizes: Maxwell and Tennyson, Kloman's, Upjohn, Lederle, Whelan Drugs, Peoples Drug Stores, Beuchler's, Gibson Company, Meredith Company, Kinner and Membre, Mead Johnson, and Sharp and Dohme.

Members of the Sports Committee are: Dr. Frank M. Hand, *Chairman*; Dr. Leo B. Gaffney, *Vice Chairman*; Drs. Norvell Belt, Alan J. Chenery, Roy F. Dunmire, Russell J. Jansen, Joseph V. Kennedy, Millard F. Ottman and Paul S. Putzki.

The Washington Ophthalmological Society presented the following program on November 5:

"The Management of Intraocular Foreign Bodies," Dr. George H. Cross of Chester, Pa.; "Plastic Reconstruction of Left Lower Eyelid following Excision of a Large Epithelioma," Dr. M. Noel Stow, with discussion by Dr. James N. Greear, Jr.; "Hy-

popylon Ulcer Treated with Penicillin," Dr. E. Leonard Goodman; "Intraocular Foreign Bodies," Dr. Thomas R. Rees; "Optic Atrophy following Hemorrhage from Duodenal Ulcer," Dr. Paul Levatin.

The Tenth National (Victory) Assembly of the United States Chapter of the International College of Surgeons will be held in Washington, D. C., at the Mayflower Hotel on December 6, 7, 8, 1945. The Program Committee in coöperation with the General Chairman, Dr. Custis Lee Hall of Washington, has secured outstanding surgeons as essayists. Prominent speakers with international reputations will address the scientific sessions as well as the Convocation and banquet. They are as follows:

Dr. Garnet W. Ault, Professor of Proctology, Georgetown University School of Medicine: "Ulcerative Colitis"

Lt. Colonel Wilbert H. McGaw, Chief of Orthopedic Surgery, Walter Reed Hospital: "Pneumographic Differential Diagnosis in Internal Derangements of the Knee Joint"

Rear Admiral Winchell M. Craig, Chief of Surgical Service, and Captain Joseph S. Barr, Chief of Orthopedic Surgery, Naval Medical Center, Bethesda, Md.: "Reconditioning of Spinal Cord Injuries"

Dr. Edgar Davis, Associate Professor of Clinical Surgery, Georgetown University School of Medicine: "Tumors of the Lung"

Dr. Charles Stanley White, Professor of Surgery, George Washington University School of Medicine: "Amino-Acids in Surgery"

Dr. J. Ross Veal, Associate Professor of Surgery, Georgetown University School of Medicine: "Circulatory Disturbances of the Lower Extremities"

Dr. Elmer Hess, Chief, Urological Department, St. Vincent's Hospital, Erie, Pa.: "Conservative Renal Surgery"

Dr. Clark Brooks, Harper Hospital, St. Louis, Mo.: "Gall Bladder Surgery"

Dr. Albert A. Berg, Mt. Sinai Hospital, New York, N. Y.: "Regional Terminal Ileitis"

Lt. Colonel Benvenuto R. Dino, M.C., Philippine Army, New York, N. Y.: "Salvaging Medical Education in the Philippines"

Dr. Emil J. C. Hildenbrand, Director, Physical Therapy Dept., Garfield Memorial Hospital: "Refrigeration in Surgery"

Dr. Roland Klemme, Professor of Neurological Surgery, Washington University, St. Louis, Mo.: "Major Neuralgias"

Dr. Moses Behrend, Philadelphia, Pa.: "Phlebitis, Embolism and Thrombosis"

Dr. James W. Watts, Clinical Professor of Neurosurgery, and Dr. Walter Freeman, Professor of Neurology, George Washington University School of Medicine: "Psychosurgery for the Relief of Unbearable Pain"

Major General Paul R. Hawley, U. S. Army (former Chief Surgeon, European Theatre), Chief Surgeon, U. S. Veterans Bureau: "Surgery in the European Theatre of Operations"

Lt. Colonel Brian Blades, Chief, Thoracic Surgery, Walter Reed Hospital: "Recent Advances in Treatment of Chronic Empyema"

Dr. Eduardo Caceres, University of San Marco, Lima, Peru: "Cancer of the Larynx"

Colonel Alfred R. Shands, U. S. Army Air Forces Chief Surgical Section, Medical Services Branch, Office of the Air Surgeon: Title to be announced.

Colonel Leonard Peterson, Consultant in Orthopedics to the Surgeon General of the United States Army: Title to be announced.

Dr. E. A. Rovinstine, Professor of Anesthesia, New York University College of Medicine: "Alleviation of Pain in Angina Pectoris by Nerve Blocking"

Dr. W. J. Carson, Preceptor in Surgery, University of Wisconsin Medical School: "Hypoparathyroidism"

The Honorable Alben Barkley, Senator from Kentucky, will be the guest speaker at the Assembly Banquet, December 8.

The President of the United States Chapter is Dr. Herbert Acuff, Knoxville, Tenn.; Dr. Louis J. Gariepy of Detroit, Mich., is Secretary.

Promotions to fill vacancies left by resignations from the faculty of **Georgetown University School of Medicine** were announced on October 27 by the Very Reverend Lawrence C. Gorman, S.J., Georgetown President. They took effect with the opening of the new term on October 29.

Dr. Henry R. Schreiber was promoted from Clinical Professor of Medicine to Professor of Medicine and Acting Director of the Department of Medicine. He fills the vacancy caused by the resignation of **Dr. Wallace M. Yater**, who had held the position since 1930.

Dr. Schreiber is a former President of the Medical Society of District of Columbia. He joined the faculty of Georgetown University in 1908, the year after graduation. His new duties include those of Acting Chief Physician, Georgetown University Hospital.

Dr. William F. O'Donnell has been promoted to the position of Professor of Pediatrics and Acting Director of that Department. He succeeds **Dr. Joseph S. Wall**, who resigned after 47 years. In 1938, upon completion of 40 years of teaching, the University awarded Dr. Wall the degree of Doctor of Science. He was graduated from Georgetown in 1897. Dr. O'Donnell is a Georgetown graduate and has been associated with the pediatrics department of the school since 1915. He was promoted from instructor to Clinical Professor in 1930.

Also promoted was **Dr. Charles A. Millwater**, to the position of Associate Professor of Clinical Pediatrics. Georgetown graduate of 1932, he has been Instructor of Pediatrics since 1936 and chief supervisor of clinical clerkships. He replaces **Dr. John H. McLeod**, who has vacated the post after 10 years. Dr. McLeod obtained his medical degree from the University of Toronto. He came to the Georgetown faculty in 1925 as Instructor in Pediatrics.

The appointment of nine consultants to assist in the health and hospital survey now under way was announced by the **Washington Metropolitan Health Council**. They were: Dr. Ethel Dunham; Miss Ruth Fisher of the National Organization for Public Health Nursing; Dr. Walter Clarke, American Social Hygiene Association; Dr. C. C. Wilson, Professor of Health Education, Columbia University; Miss Mary Jarrett; Donald Cordes, Executive Assistant, St. Luke's Hospital; Mrs. Edith Seltzer and Charles G. Boswell, both of the United Hospital Fund, New York City; and James R. Clark, Director of the Washington Bureau of the American Hospital Association.

President Truman endorsed the observance of the **National Hearing Week** which began October 21. In a communication addressed to Dr. C. Stewart Nash, President of the American Society for the Hard of Hearing, he said:

"In this year of 1945 we have accomplished, through research, much on how to alleviate maladies and aid many hundreds of handicapped individuals.



MAJOR GENERAL PAUL R. HAWLEY, Acting Surgeon General of Veterans Administration, welcomes DR. PAUL B. MAGNUSON, of Chicago, into the medical service of the Administration. Dr. Magnuson will leave his post as Associate Professor of Surgery at Northwestern University School of Medicine to become Director of Research and Postgraduate Training of Veterans Administration.

"Our Army, Navy and Veterans Administrations have launched a very extensive program for rehabilitation and through the splendid efforts of the American Society for the Hard of Hearing, now celebrating its twenty-sixth anniversary, we shall gain tremendously in attaining victory for many who suffer the handicap of impaired hearing.

"I have been pleased with the assurance that the splendid work being done by the American Society for the Hard of Hearing is known and appreciated by those agencies of the government whose concern is the alleviation of human suffering through the advancement of the art of healing. You and your associates are engaged in a work of the highest value which deserves to succeed.

"Each new achievement has brought into sharp relief the work yet to be done and has been a spur to greater accomplishment. Consequently, I heartily endorse the observance of National Hearing Week, beginning October twenty-first next."

Dr. Claude Moore, Washington Counsellor for the American College of Radiology, was appointed to the advisory committee planning the celebration of the fiftieth anniversary of discovery of X-rays. A nationwide observance of this event took place during the week of November 5 to 10. A part of the

program included educational features to acquaint the public with the development of the X-ray as a medical instrument and its contribution to the health and well being of every individual.

The George Washington University Medical Society, at a meeting on October 20, sponsored a Symposium on Pulmonary Disease. Papers presented were as follows: "The Pneumonias, Early Recognition and Treatment," Dr. Harry F. Dowling, Clinical Professor of Medicine, George Washington University; "Bronchiectasis and Associated Pulmonary Lesions," Dr. Russell K. Hollingsworth, Associate in Surgery, George Washington University; "Pulmonary Infarction," Dr. J. Ross Veal, Associate Professor of Surgery, Georgetown University. The subject was discussed from the viewpoint of medicine by Dr. Walter A. Bloedorn, Dean and Professor of Medicine, George Washington University; from the viewpoint of surgery, Dr. Charles S. White, Professor of Surgery, George Washington University; from the viewpoint of radiology, Dr. Arthur C. Christie, Professor of Clinical Radiology, Georgetown University; from the viewpoint of pathology, Dr. Roger M. Choisser, Professor of Pathology, George Washington University.

The Jacobi Society announces that the following officers have been elected for the year 1945-46:

Dr. Lester Neuman, *President*; Dr. Benjamin Golden, *Vice President*; Dr. Edward Cafritz, *Treasurer*; Dr. Leon Gerber, *Secretary*.

A short course on Ocular Motility, primarily intended for the residents of Episcopal Eye, Ear and Throat Hospital, began October 29. It will conclude on December 13. Instructors in the course are Drs. Frank D. Costenbader, Ernest Sheppard and Richard W. Wilkinson, and Alice McPhail, R.N.

Dr. Leopold Wexberg has been appointed Chief of the Health Department's **Mental Hygiene Bureau**. He began his duties in the Health Department, November 1. Dr. Wexberg was recently discharged from the U. S. Army with the rank of Major. He had been in charge of neuropsychiatric sections of hospitals in the Panama Canal Zone, Camp Adair, Oregon, and Camp Beale, California.

Before entering the Army in 1942 Dr. Wexberg was Visiting Professor in Neuropsychiatry at Louisiana State University, and Senior Medical Officer at Fairfield State Hospital, Newton, Conn. He came to the United States in 1933, after 19 years of practice in Vienna.

Dr. Wexberg succeeds Dr. George F. Owens, who resigned last June because of inadequate facilities.

The 1945 Gorgas Medal was awarded to **Captain Lowell T. Coggeshall, M.C., U.S.N.R.**, on October 29, at a dinner given at the Mayflower Hotel, for his work in filariasis. Captain Coggeshall was formerly Director of Malaria Research at the Rockefeller Foundation. The medal, together with an honorarium of \$500, was presented to Captain Coggeshall by Frank E. Law, Vice President of Wyeth, Inc., of Philadelphia. The award is made annually by the Association of Military Surgeons of the United States.

Miss Mattie M. Gibson, Superintendent of Children's Hospital, began her 26th year at that institution on October 19. A tea was given in her honor by approximately 500 members of the Board of Directors, Board of Lady Visitors, and medical, nursing, Red Cross and maintenance staffs, in celebration of the event. Miss Gibson is dean of Washington hospital superintendents.

Mr. Charles D. Drayton, who spoke at the tea, was quoted in the *Washington Evening Star* as saying, "The names Miss Gibson and Children's Hospital have become synonymous." Many gifts were presented to the popular Superintendent, including checks for varying amounts; a special citation for her work during the War Bond campaigns, presented by George B. Ingels of the District War Finance Committee; an illuminated scroll and leather desk set from the medical staff; a diamond wrist watch from the Board of Lady Visitors; and an antique desk from the nursing staff.

Much credit is given Miss Gibson for the improvement in hospital service in Washington. Children's Hospital, under her direction, has become one of the outstanding institutions of its kind in the country.

Miss Gibson was one of the few nurses to serve immediately behind the front lines in World War I.

Dr. George C. Ruhland, District Health Officer, has appointed a committee to advise him on tuberculosis problems in Washington. Dr. James G. Townsend of the United States Public Health Service, has been made Chairman. Members of the advisory group are: Dr. Samuel Ingraham, U. S. Public Health Service; Miss Gertrude Bowling, Executive Director, Instructive Visiting Nurse Society; Edward F. Funkhouser, Executive Secretary of the local Tuberculosis Association; Dr. Howard M. Payne, Howard University; Dr. LeRoy Dunn, District Medical Society; Dr. Daniel L. Seckinger, Assistant Health Officer; Dr. A. Barklie Coulter, head of the Bureau for Tuberculosis of the Health Department; Dr. Daniel L. Finucane, Superintendent of Glenn Dale Sanatorium; Mrs. Josephine Prescott, head of the Public Health Nursing Bureau of the Health Department; Dr. Alvin R. Sweeney, Superintendent, Gallinger Municipal Hospital; and Dr. Melvin P. Isaminger of the Health Department, who will be Secretary.

The Red Cross Nurses' Aide Rally was held at the Department of Interior Auditorium, October 25. Speakers were Major Milton Freedman of Walter Reed Hospital; Mr. Leo Schmelzer, Superintendent of George Washington University Hospital; and Miss Edith M. Beattie, Executive Secretary of the Graduate Nurses Association. Among the guests were superintendents of all District hospitals.

The Section on Gastroenterology held a meeting in the Pan American Room of the Mayflower Hotel, October 15. Dr. Clapham P. King was host. Dr. M. Paulson, Assistant Professor of Medicine, Johns Hopkins University, addressed the Section on the "Practical Medical Aspects of Subtotal and Total Gastrectomy." Participating in the discussion were Drs. Joseph P. Shearer, Charles S. White, Harry L. Claud and William Earl Clark.

The Society's Executive Board decided to discontinue the **Committee on War Participation** at its meeting, October 22.

Dr. Frederick C. Fishback has been appointed a member of the Committee on Relations with the Legal Profession. **Dr. Harry Lee Claud** has been appointed Chairman of the new Classification Com-

mittee to succeed Dr. F. X. McGovern. These appointments were submitted by President Clark to the Executive Board at the same meeting. The Board promptly confirmed the appointments.

Miss Catherine Moran retired, October 1, as Superintendent of Nurses of **Gallinger Municipal Hospital** after 23 years of service. A reception was given in her honor at which she was presented with a gold watch by her associates. More than 200 were in attendance.

Dr. J. Blaine Harrell was sworn in as a member of the District Board of Police and Fire Surgeons, October 3. He succeeds Dr. F. X. McGovern, who has resigned. Both men were appointed until the return of Dr. W. Warren Sager, who has been on active military duty since 1942.

Major Henry B. Gwynn, M.C., A.U.S., has been elected a member of the Baruch Committee on Rehabilitation and Reconditioning.

Dr. Vasilios S. Lambros presented a paper on "The Convulsive State" before a meeting of the Montgomery County Medical Society, September 18.

Through an error, **Captain Lee McCarthy, M.C., U.S.N.R.**, was listed as Lt. Commander in the Secretary's last letter to service physicians. Captain McCarthy is now stationed in the office of the Surgeon General of the Navy and expects to return to private practice before long.

Captain Winchell M. Craig, M.C., U.S.N.R., of the Naval Medical Center, Bethesda, Md., well known to many Washingtonians, has been promoted to the rank of Rear Admiral.

Dr. Joseph S. Wall, Dr. Herbert P. Ramsey, and Theodore Wiprud represented the Medical Society at the Public Relations Conference sponsored by the American Medical Association's Council on Medical Service and Public Relations, held in Chicago on October 19 and 20.

Dr. Samuel Benjamin recently returned from Boston where he has been doing postgraduate work at Harvard Medical School.

WOMAN'S AUXILIARY NOTES

For Active Membership

The Woman's Auxiliary to the Medical Society of the District of Columbia held its first meeting of the season in the library of the Medical Society's building. Mrs. William Earl Clark, the newly elected President, presided. Assisting the President were the following officers: Mrs. Arch L. Riddick, First Vice President; Mrs. George H. Crofton, Second Vice President; Mrs. Harry S. Lewis, Treasurer; Mrs. Richard H. Todd, Secretary; and Mrs. D. C. Richtmeyer, Corresponding Secretary.

After a well attended and interesting business meeting the Auxiliary was honored to have Mr. Lancelot Sukert as guest speaker, who gave a beautifully Kodachrome-illustrated lecture on "The Gardens of Dumbarton Oaks." A delightful luncheon was served by the House Committee, of which Mrs. Richard E. Dunkley is the Chairman. Assisting at the table were Mrs. William Thornwall Davis and Mrs. Ralph S. Pendexter.

The Auxiliary wishes its newly elected President and officers a most successful year.

MRS. WILLIAM J. B. ORR

Publicity Chairman

MEMBERSHIP

The following applicants for membership were duly elected to membership at the business session, October 10, 1945:

Active Members

Samuel M. Bageant, 5600 New Hampshire Avenue, N.W.
Clifford E. Bagley, 1801 Eye Street, N.W.
John E. Cassidy, 2520-14th Street, N.W.
John A. Collins, 2923-45th Street, N.W.
Charles F. Forester, 1224 M Street, N.W.
Maurice Franks, 1328 Eye Street, N.W.
Louis J. Goffredi, 1801 Eye Street, N.W.
John A. Long, Captain, M.C., Army of the United States
Isabelo R. Villaroman, 7407 Georgia Avenue, N.W.

Associate Members

John W. Cronin, U. S. P. H. S. Dispensary, 4th and D Streets, S.W.

The following applicants for membership will be voted on at the business session, December 12, 1945:

John Henry Bayly, Georgetown University—1940
Samuel Maurice Becker, George Washington University—1926
Benjamin Parks Bell, University of Oklahoma—1942
Lester Sylvan Blumenthal, George Washington University—1941
Frederic Gerard Burke, Georgetown University—1942
James Theodore Burns, George Washington University—1936
Andrew Nicholas Conte, Georgetown University—1942
Joseph Henry Cowan, Ohio State University—1922
Francis Stephen DeCoste, Georgetown University—1943
Vincent James Di Francesco, George Washington University—1940
James Spencer Dryden, Medical College of Virginia—1933
Paul Holley Gray, University of Chicago—1942
Charles Raymond Headlee, Indiana University—1944
Charles Frederick Hill, Georgetown University—1915
Paul Fleming Holland, University of Athens, Greece—1936
Eloise Whittlesey Kailin, George Washington University—1943
Edward A. Krause, George Washington University—1927
Charles K. Latven, Georgetown University—1936
Joseph S. Lawrence, Johns Hopkins University—1916
Abraham Al Levine, George Washington University—1936
William Lewis, Jr., George Washington University—1941
Michael Morgan Miller, University of Vienna—1937
Anthony Joseph Nicolette, Georgetown University—1937
Blanche Widome Nimetz, George Washington University—1938
Francis J. O'Bryan, Georgetown University—1933
Raymond Allen Osbourn, Georgetown University—1940
Charles Sumner Robbins, Rush Medical College—1901
Ruth Esther Standard, College of Medical Evangelists—1941
Micollus Noel Stow, Emory University School of Medicine—1939
Joseph H. Thibadeau, Georgetown University—1943

For Associate Membership

George David Adams, George Washington University—1943
Dean Herbert Harding, University of Kansas—1943
Charles D'Arthèz Lardé, National University of El Salvador, C.A.—1921
William Cecil Manion, Georgetown University—1943
Nicholas George Pistolas, Georgetown University—1942
Weldon Aubrey Price, Georgetown University—1934
Charles Waters Thompson, George Washington University—1941
Charles Cecil West, University of Maryland—1919
Karl Hayden Wood, D.D.S., Georgetown University—1933

MEETINGS

Wednesday, December 12

Speaker and subject to be announced.

ALBERT McELROY WHEELER, M.D.
(1901–1945)

Captain Albert M. Wheeler, a practicing physician in Washington for nine years before he entered the Army Medical Corps in April, 1941, died August 11 in Mourmelon le Grand, France, three days before the end of the war. According to a fellow officer, he suffered a heart attack. His death is the third among the Medical Society's membership directly attributable to service during World War II.

Dr. Wheeler was born in Wheeling, West Virginia, November 30, 1901. He received his degree in medicine from the University of Arkansas in 1930 and practiced for a very brief period in Wheeling. He came to Washington in 1932, and maintained his office at 1317 Rhode Island Avenue, N.W.

Captain Wheeler was stationed at Fort Myer, Va. and Fort Knox, Ky, before going to Northern Ireland in April, 1942, with the 47th Medical Battalion. His battalion was with the 1st Armored Division in the invasion of North Africa. He took part in the Anzio landings and later entered Rome as Commanding Officer of Company "C" of the 47th Battalion. In August, 1944, he was transferred to the 9th Evacuation Hospital and served with it in France until the defeat of Germany. In a letter written in June, 1945, he stated, "I have 124 points to return but I've decided and been reassigned to the Pacific theater." He was reassigned to the 88th Medical Battalion for redeployment to the Pacific.

Captain Wheeler received a citation from General Mark Clark and was serving with the 9th Evacuation Hospital when the unit was awarded a meritorious service plaque by Colonel Myron P. Rudolph.

He was a Fellow of the American Medical Association, and an Active Member of the Medical Society of the District of Columbia since 1937. He was active in the Y.M.C.A. program in Washington, and affiliated with the Masonic Order, the Phi Chi and Delta Chi fraternities.

Surviving are his father, Albert C. Wheeler of Wheeling, West Virginia; a sister, Mrs. John A. Lawther of Bethesda, Md.; and a brother, William S. Wheeler, of Detroit. While practicing here he made his home with Mrs. Frank Tipton and the late Dr. Tipton at 1324 Farragut Street, N.W.

Small Coronary Vessels—Roberts

(Continued from page 495)

The blood supply of peripheral nerves has been shown to be of importance in their function, and this may be interpreted to indicate that ischemia of the myocardial and periarterial nerves may be an important factor in modifying cardiac pain.

Attention is drawn to the theoretical importance of the cardiac lymphatic vessels in myocardial metabolism.

I am indebted for assistance to all the institutions and companies listed in the footnote on page 483, to the collaborators named in the bibliography, and to all others who helped in any way. Opportunities to work and critical encouragement have been given during various phases of this work by Drs. Joseph T. Wearn, Harold Cummins, Claude S. Beck, George Herrmann, Donald Duncan, John W. Spies, John G. Sinclair, Chauncey D. Leake, Harry F. Dowling, Wallace M. Yater and others.

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Acute Anterior Poliomyelitis—Sweet

(Continued from page 504)

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Postgraduate Course Scheduled—Observer

(Continued from page 518)

The Committee came to some interesting conclusions with regard to this and other courses to follow. It agreed that there was a need for the integration of courses so that there would be continuity in its educational program. Then, too, it was thought that the POSTGRADUATE COURSE IN DIAGNOSIS would be so popular that another in which other subjects are covered should be held in the spring.

Members of the Society can look forward with keen anticipation to this and other courses which the Committee will offer this year.

There Are There have been times when
Compensations writing has become so onerous
your Observer has seriously con-
sidered abandoning this column. When in
this state of mind, he thinks only of the drudgery
of a task which must be done with distressing
regularity. Convinced it is not worth the effort,
he has toyed with the idea of engaging in some-
thing more pleasant and far less arduous.

Some find it more difficult than others to transfer their thoughts to paper. They achieve coherence and effectiveness by sheer perseverance. On the other hand there are those who write without effort. Words seem to flow with the slightest effort, and their first drafts usually need little correction. But these individuals are the exception rather than the rule. Your Observer is decidedly in the first category. He finds it necessary to revise his original drafts from three to four times. Even then he may find them unsatisfactory. Whereupon he destroys what he was written and makes a new beginning. Finally a passable manuscript may be completed.

There are, of course, better days when your Observer comes to think himself quite a fellow. He actually believes his column has contributed in a very modest degree toward his longtime objectives, that of developing better physicians and bringing about a wider distribution of good medical service. There is some evidence to support this view, although this may be open to debate.

Lest the impression be gained that your Observer takes himself too seriously, he hastens to say that he has no illusions about himself. He will be content if medicine is the very smallest fraction better for his having been around.

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THE "TYPICAL" HEADACHE OF ESSENTIAL HYPERTENSION

Etiologic Considerations and Report of a New Form of Therapy

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THE "typical" headache of uncomplicated essential hypertension is a symptom for which a conclusive physiopathologic explanation has not yet been formulated. Therapy has been for the most part designed to lower blood pressure. Results of such therapy^{1,2} have been unpredictable and unsatisfactory in many cases.

It would seem that etiologic considerations have not been sufficiently evaluated. The purpose of this paper is to review experimental and statistical data and to present a series of cases of the "typical" headache in which treatment was based on a premise obtained from analysis of the aforesaid data.

Janeway³ and others^{4,5} have described this headache in the following way: "The headache is one which appears on awakening or wakes the patient during the early hours, has its greatest intensity before arising and passes away during the course of the morning hours or immediately after breakfast to reappear in the same manner

day after day for considerable periods." From this series of cases, the recurrence of headache during emotional stress or fatigue might be added to the above description.

ETIOLOGIC CONSIDERATIONS

There is an abundance of literature indicating that this headache is of psychogenic origin and possibly not produced by the elevated arterial tension per se. Robey⁶ found the headache not related to the height of the blood pressure nor to the pulse pressure. He found the systolic and diastolic pressure to be the same in 50 cases of headache as in 150 cases in which the patient never experienced headache. Sutherland and Wolff⁷ recorded the blood pressure hourly in 4 hypertensive subjects for 3 days. They found no correlation in the individual between the blood pressure level and either the occurrence or intensity of the headache. Janeway³ and Sutherland and Wolff⁸ found a significant percentage of their patients to have had headache

of a migrainous sort for years before the advent of the hypertension. Gardner et al⁹ found migraine to be 5 times as common in hypertensive patients as in a group of controls. These authors also found that the individual with a migraine history is more likely to experience a "typical" headache with hypertension. O'Hare et al¹⁰ recorded a history of migraine or other vasomotor phenomena in 46 per cent of 300 cases of hypertension. A control group gave such a history in only 26 per cent of cases.

Tucker¹ and Sutherland and Wolff² found that drugs reducing blood pressure are not very successful in relieving headache. The latter authors found that amyl nitrite increased the aching. They agree that periods of rest and relaxation, week ends in bed, vacations at a restful spot, and a simple hobby are effective therapy for this headache. They conclude that a drop in blood pressure is not necessarily an accompaniment of relief. Weiss and English¹¹ cite cases of headache in hypertensives relieved by psychotherapy without a reduction in blood pressure. These authors make no mention of morning headache occurring in their cases.

Shelburne et al¹² studied spinal fluid pressures in relationship to occurrence of headache and papilledema in 50 cases. They concluded that increased intracranial pressure does not account for headache in hypertension unless papilledema is seen in the fundus. Sutherland and Wolff⁸ recorded the same observations.

Schumacher and Wolff¹³ found dilated, tender, temporal arteries in their cases. In each case pressure occluding the circulation in the dilated segment of artery relieved the cephalalgia. If the artery was not palpable, occluding the common carotid on the side of the aching gave relief. They also were able to abolish pain with the intravenous use of ergotamine tartrate. Simultaneously with the relief of pain there was decrease in the amplitude of pulsation of the dilated artery and a rise in blood pressure. They concluded that the source of pain in the typical

headache of hypertension is the same as in migraine, a dilated extracranial artery.

Thus it would seem that the typical headache of uncomplicated essential hypertension is but one functional manifestation of a basic psychogenic disturbance. The relationship of the cephalalgia to migraine is very apparent and possibly it might be called true migraine or a migraine variant.

Upon this concept is based the ergotamine therapy described in a review of cases.

Not unlike migraine the "typical" headache appears after a night's sleep in the horizontal position and is relieved on standing erect. Upon the premise that recumbency seems to favor production of the cephalalgia, the present experiment was instituted. Patients were instructed to elevate the headposts of their bed on 10-inch high wooden blocks or an equivalent in bricks.

Allen and MacLean¹⁴ reported in 1940 1 case treated with 18-inch elevation of the head of the bed. They observed the patient in the hospital for 10 days. A striking correlation between the use of elevation and absence of headache, as well as the reverse relationship, was noted.

DIAGNOSIS

Final diagnosis of this type of headache must be made by exclusion. However, in a case of uncomplicated essential hypertension occurrence of headaches on awakening, relief on standing up, and complete disappearance during the course of the morning hours, suggests the diagnosis of "typical" headache.

Finding a dilated artery in the area of pain distribution is further confirmatory evidence. Relief of pain by manual occlusion of the artery and/or by the use of ergotamine tartrate intravenously establishes the diagnosis.

If no dilated arterial segment can be palpated, occlusive pressure over the homolateral common carotid will relieve the headache. Any of the extracranial arteries may be the source of pain.

DIFFERENTIAL DIAGNOSIS

Hypertrophic arthritis of the cervical spine presents the most difficult problem in differential diagnosis. This condition occurs in the same age group with essential hypertension. Patient no. 7 had pain from cervical arthritis and the "typical" headache. In cervical arthritis chilling or exposure to draft may start the headache. Pain is usually present in bouts of 3 to 5 days' duration. Aching in arthritis is occipital with radiation to the vertex or temporal region. In the "typical" headache it is usually in the temporal or frontal region but may be occipital. In cervical arthritis headache comes after the patient has been in bed a while or may wake him up after several hours of sleep.

Radiation of the pain to the neck, shoulders and arms with associated aches and stiffness in the knees and back are additional evidence of hypertrophic arthritis.

Physical findings consist of Heberden's nodes of the fingers, painful limitation of neck motion in one or more directions, and tenderness of attachment of the trapezius to the skull. Roentgen features are general decalcification of the vertebral bodies, narrowing of the intervertebral spaces, and lippling.¹⁵

Sinus headaches are less frequent when the patient has been recumbent for a period and are more often present during the day than during the night. Pain in antral infection usually appears early in the afternoon. Frontal sinus aching starts early in the morning, gets worse during the day and may end in the early evening. In all instances the pain is a dull ache, not throbbing as in the typical headache, and not associated with nausea or emesis.¹⁶

Pain from brain tumor is intermittent and only a moderately severe, deep, dull ache, non-pulsatile in character. Usually the pain is worse in the erect position, but it may wake the patient up at 3 or 4 a.m. If intracranial pressure is increased there may be a moderate hypertension. The presence of papilledema,

bradycardia and neurologic findings differentiate this from the "typical" headache.¹⁷

Pain from migraine may start in the early morning hours and awaken the patient from sleep, but it usually starts during the day. There is sometimes an aura, most often visual, preceding the attack. If the aura outlasts the headache, suspicion of brain tumor or vascular accident should be aroused. The location of the pain may be anywhere on the face, neck or scalp. Limitation of pain to the same side in each attack may indicate the presence of an aneurysm of the circle of Willis.¹⁵

In late syphilis and early meningovascular syphilis there may be morning occipital headache but not usually.

Histamine headache did not occur in more than 150 cases of hypertension observed in the clinic. Compression of both external jugular veins relieves this headache.²

Headache due to hypertensive encephalopathy is associated with anorexia, emesis, apathy, restlessness, weakness and amblyopia. It is only one of a set of prodromal symptoms preceding convulsive seizures by several days. The cephalalgia is severe, may radiate to the back of the neck and be unilateral as in migraine. Presence of papilledema and extreme elevation of blood pressure will be present to help in the diagnosis.¹⁸

REPORT OF CASES

Case 1.—V. S. (No. 35714) The patient was a 47-year-old colored woman admitted to the dispensary in March 1943 complaining of bitemporal and occipital headache of a dull, pounding nature. There was associated nausea and rarely, emesis. The onset had been 2 years previous. The patient awoke with the aching, which was relieved in several hours but which occasionally would persist all day. Nervousness increased the intensity of the pain. Recently these had been of daily occurrence. As a young girl she had had headaches, nausea and emesis at the time of menstrual period. Hot flushes and decreased menses had been noted for the past 2 years. Her blood pressure was 240/140.

The cold-pressor test was negative. Wassermann test, complete blood count, nonprotein nitrogen, urinalysis,

basal metabolic rate, and urine concentration test were all normal.

She was given stilbestrol, 0.25 mg. per day orally, and theelin intramuscularly. Phenobarbital, 0.03 Gm. ($\frac{1}{2}$ grain) 4 times a day, was also prescribed.

She returned April 7, 1943, having experienced no relief of pain. The blood pressure was 200/120. Ten-inch blocks under the head of the bed were advised. She was seen on May 11, 1943 and stated that her headaches were of less frequency and severity. The blood pressure was 230/130. Subsequently she had a left hemiplegia. On August 1, 1943 a Smithwick splanchnic section was done. The patient was not seen again until November 8, 1944, at which time she complained of recurrence of headache for the preceding 2 months. The blood pressure was 200/100. Thiocyanate was given, and, although the blood pressure dropped 20 mm., she obtained no relief. Ten-inch blocks were advised. The patient volunteered that she had originally only used a 3-inch block. She was impressed with the need of more elevation. She returned a month later complaining of very occasional morning headache abolished as soon as she stood up. When last seen on May 28, 1945 she said she had had only 2 morning headaches and that standing up gave immediate, complete relief. She was still sleeping on 10-inch blocks. The blood pressure was 170/110.

Case 2.—J. B. (No. 35717) The patient was a colored man 55 years of age. He was admitted to the clinic on April 7, 1943 complaining of dull frontal and occipital headaches on awakening and relieved after being out of bed 10 or 15 minutes. The onset was between 2 and 3 years before. Hypertension had been discovered 2 years before. Exertional dyspnea and angina of effort had been present for 1 year. The blood pressure was 240/140. Cardiac enlargement and A-V nicking were found on physical examination. Digitalization was instituted.

An intravenous pyelogram revealed normal kidneys with good dye concentration. The non-protein nitrogen was 50 mg. per 100 c.c. of blood. The urine showed an occasional granular cast and a trace of albumin. The cold-pressor test was negative. Complete blood count and basal metabolic rate were normal.

The patient was observed on May 25, November 9, and December 8, 1943. During this time the headache was persistent. The blood pressure averaged 230/120. On December 8, 1943 he was instructed to place 10-inch wooden blocks under the headposts of his bed. On December 22, 1943 he reported complete remission of the headache since the use of the blocks. When last seen, May 10, 1944, he stated that he had not had recurrence of the headache.

Case 3.—J. W. (No. 35018) The patient was a 52-year-old colored male admitted to the clinic on August 21, 1943 complaining of severe occipital and frontal headache occurring almost daily for the past year. This headache was present on awakening and was relieved on assuming the erect position. Complete disappearance of the aching came later in the morning. The ocular fundi showed "silver-wire streaking" and tortuosity of the small arteries. The blood pressure was 180/115. Laboratory examinations were normal.

He had had a right hemiplegia in July 1943 and showed some residuals. Aminophylline was given, 0.1 Gm. ($1\frac{1}{2}$ grains), 4 times a day. The patient returned on September 1, 1943, and the headaches were only slightly better. The blood pressure was 165/115. He was instructed in the use of 10-inch wooden blocks. On September 13, 1943 he had experienced a great deal of relief of severity of the headaches. The blood pressure was 150/110. He was not seen again until April 13, 1945. He had been sleeping on his blocks, and the headaches had undergone complete remission. The blood pressure was 120/80. At that time he was in grade III congestive failure and had symptoms of a malignant lesion which proved to be a melanosarcoma.

Case 4.—A. L. (private case) The patient was a 48-year-old white woman whose hypertension had existed 10 years or longer.

She had had a complete hypertensive work-up including estimation of 17-ketosteroid output, intravenous pyelogram, nonprotein nitrogen, complete blood count, and urinalysis, all of which were normal. Her pressor test was markedly positive, and intravenous pentothal anesthesia caused her blood pressure to drop from 260/150 to 130/80.

A year previous to the onset of the headache she had a Smithwick splanchnic section with excellent result. She had never experienced headache at any time during her life. I saw her on April 1, 1945 at about 8:00 a.m. She had been having headaches on awakening for the previous week. These were frontal and of a dull, heavy, aching character. They were relieved on arising and disappeared shortly after breakfast. The blood pressure was 170/110. Pressure over the superficial temporal arteries relieved the aching, although no dilatation of these vessels was demonstrable. Ergotamine tartrate, 0.2 c.c., was given intravenously, and although the blood pressure did not change the headache disappeared. She was told to elevate the head of her bed on 10-inch blocks. Five days later she called to inform me that her headache had not recurred. She suffered an emotional shock the following day and that evening died of a massive cerebral hemor-

rhage. The blood pressure after the onset of the apoplexy was 200/110.

Case 5.—M. S. (No. 31718) The patient was a 47-year-old white woman admitted to the clinic, March 28, 1945. She complained of dull, heavy frontal and vertex aching. This had been present intermittently for the past year. The headache was worse on awakening and relieved after getting out of bed to disappear in the forenoon. However, the pain might be present all day. In the past 3 months these headaches had been present daily and had increased in intensity. For 20 years the patient had had headaches with associated nausea. This type of headache usually came during the day and was relieved by bed rest. Her hypertensive state was discovered in 1939. She was a diabetic and well controlled.

Complete blood count and urinalysis were normal; the basal metabolic rate was plus 26.

The blood pressure was 190/100. Pressure over both superficial temporal arteries relieved the pain, and 0.1 c.c. of ergotamine tartrate intravenously abolished the aching. Dilated temporal arteries were not demonstrated. The blood pressure rose to 200/100 after intravenous medication. Ten-inch blocks were prescribed. The patient returned on May 7, 1945. She had had no headaches since using the blocks. On June 29, 1945 the blood pressure was 180/90. The headaches had not recurred.

Case 6.—L. M. (No. 36949) The patient was a 58-year-old colored woman who was admitted to the clinic on April 30, 1945. She complained of severe occipital and frontal aching most marked at the time of waking and relieved after getting up. The headache usually persisted all day with greatly decreasing intensity. The use of an ice bag to the head gave relief. The onset of the headaches had been about 6 years before at about the time the hypertension was discovered. In the last 3 months she had had headaches daily and there had been an increase in severity. The patient's mother had severe headaches with associated nausea and emesis, but no hypertension. The patient's blood pressure was 210/150.

On May 16, 1945 she returned with the same complaint. The blood pressure was 170/100. The right anterior temporal artery was dilated about 3 times the size of the left anterior temporal. Pressure occluding the right superficial temporal artery relieved her pain. Ergotamine tartrate, 0.5 c.c. given intravenously, abolished the headache completely, and the size of the dilated artery approximated that of the contralateral vessel. The blood pressure did not increase after ergotamine tartrate was administered. Elevation of the head of her bed on 10-inch blocks was advised. She returned on May 25,

1945, feeling much better. The blood pressure was 210/120. The headaches were still persistent although not as severe. Ergotamine tablets 4 times a day were prescribed. On June 6, 1945 she stated that when startled into waking a headache would be present but would disappear on standing up. Waking up naturally was not attended with aching. The headache still occurred during the day but was of much less intensity. The right anterior temporal artery was still dilated but not as much as previously. The blood pressure was 180/100. Ergotamine therapy was stopped. On June 11, 1945 the morning headaches were reported to have stopped completely. During the day she was still having occasional mild frontal aching. The blood pressure was 200/104. On June 25, 1945 the patient reported complete absence of headaches. The blood pressure was 210/120.

Case 7.—K. G. (No. 36525) The patient was a 50-year-old white woman who was admitted to the clinic August, 1944. She complained of moderate to severe frontal and occipital headaches. Radiation of pain down her neck and into the shoulders had been present. She had been unable to raise her arms because of attendant distress in both shoulders. Headaches had occurred throughout her life, but there had been an increase in severity for the past 5 years. Hypertension was discovered preoperatively in 1942. The cephalalgia was present on awakening and disappeared about midday. The blood pressure was 175/110. Head motion was limited in all directions, and tenderness over the attachment of the trapezius muscle to the skull was elicited. Heberden's nodes of the fingers were noted. A roentgenogram of the cervical spine revealed marked hypertrophic arthritis.

Neck traction therapy was advised. The patient returned on October 17, 1944 after a course of 10 traction treatments; her arms and shoulders were no longer painful and had full range of motion. Her headaches were then only frontal. Ten-inch blocks were advised. The blood pressure was 185/120. By November 14, 1944 her headaches had not been benefited, and 0.1 c.c. of ergotamine tartrate was given intravenously with complete relief of pain. A week later the patient informed me that no morning headaches had been experienced during the past week. The headaches had come only when she had been emotionally disturbed. The blood pressure was 170/110. The patient returned on January 23, 1945, and, although she had removed the blocks from her bed, she had had no recurrence of morning headaches. On May 16, 1945 she came in with frontal headache, very much perturbed about home conditions. She no longer suffered morning headache but did get aching when she

was emotionally disturbed. The blood pressure was 190/120. Pressure over both superficial temporal arteries relieved her headache. Dilated arteries were not demonstrable. Ergotamine tablets were given, but the patient has not returned.

Case 8.—D. H. (No. 36635) A negress aged 33 years was admitted to the clinic on October 31, 1944 with the complaint of morning occipital headaches. These were of a dull aching character and present every day on awakening. Aspirin relieved the pain, but it occasionally lasted all day. Nausea and amblyopia were occasionally associated with the complaints. She had had intermittent headaches for many years. Her hypertension had been discovered near the end of pregnancy in September 1944. The blood pressure was 200/120. Fundoscopic examination revealed A-V nicking and blurring of the nasal side of right disc.

An intravenous pyelogram revealed increased mobility of both kidneys. The basal metabolic rate was plus 10. Urinalysis showed 2 plus albumin. The nonprotein nitrogen was 27 mg. per cent.

The patient was put on magnesium sulfate 3 times a week, ammonium chloride 8 grams per day, and a fluid intake of no more than 1,500 c.c. per day. She was seen again on November 14, 1944 and had not improved. The blood pressure was 160/110. Ten-inch blocks under the bedposts of her bed were advised. On November 21, 1944 she reported that the morning headaches had disappeared completely. Occasional blurring of vision was still noted. The blood pressure was 230/140. On December 26, 1944 she had had only 1 morning headache since the last interview, and it was very mild. The blood pressure was 192/120.

It was decided to give her a trial period without any therapy. She was instructed to remove the blocks from under her bedposts. Returning on January 9, 1945 she said she had had no headaches. The blood pressure was 220/130. From then until April 4, 1945 she had only 2 slight headaches during the day. The blood pressure was 200/126. On June 19, 1945 the blood pressure was 230/134, and the patient had no complaints.

Case 9.—E. S. (No. 36805) A negro 58 years old was admitted to the clinic, February 28, 1945. His complaints were dull frontal headaches on awakening, painful limitation of motion of the left shoulder, and pain in the left side of the neck, of 2 years' duration. The headaches had been of daily occurrence for the previous 3 months. They usually disappeared after he got up but sometimes had lasted all day. Since the age of 17 he had had "sick nauseating" headaches. His mother also had headaches and associated emesis. His blood pressure was 190/110.

Fundoscopic examination revealed A-V nicking. Slight limitation of motion of head in all directions was present.

The blood nonprotein nitrogen was 28 mg. per cent; hemogram, Wassermann test and urinalysis were all normal. The patient was referred to the orthopedic department and was pronounced not an orthopedic problem.

Ten-inch blocks were prescribed. He returned on April 6, 1945 and reported a lessening in severity of the headache. The blood pressure was 220/140. Nicotinic acid, 200 mg. per day, was given.

On April 12, 1945 the patient had made no further improvement. Dilated anterior temporal arteries were noted, and pressure over both superficial temporal arteries relieved the frontal aching. Ergotamine tartrate, 0.2 c.c. intravenously, abolished the headache and there was simultaneous decrease in size of both anterior temporal arteries. The blood pressure before and after ergotamine tartrate was 195/110. One ergotamine tablet after each meal and at bedtime was prescribed.

Returning a week later, the patient stated that on the second day of ergotamine therapy his headaches had disappeared and had not recurred. The blood pressure was 205/115. Ergotamine therapy was prescribed intermittently.

By April 27, 1945 the headaches had not recurred, and the anterior temporal arteries were not dilated. The blood pressure was 190/130. The patient was instructed to return in 3 months, but if cephalalgia recurred to come in sooner. Blocks were to be continued. The patient returned July 5, 1945. While out of the city and off of his blocks his headaches had recurred. On his return, the use of blocks once again had given him complete relief, and he has had no headaches for the past 2 months. The blood pressure was 190/130.

Case 10.—G. V. (No. 24520) The patient was a 60-year-old white female admitted to the clinic, October 19, 1943. Her complaint was frontal headaches which awakened her between 2 and 6 a.m. The onset had been 2 or 3 years before. These headaches were relieved by standing up, at times disappeared about noon, and at other times persisted all day. Recently they had been of daily occurrence and recurred every evening. The patient had never had headaches before. The blood pressure was 190/90. Fundus of eye revealed A-V nicking. Limitation of head motion was slight.

The cold-pressor test was negative. Roentgenograms of the cervical spine revealed no abnormality. The blood nonprotein nitrogen was 42 mg. per cent, the cholesterol 133 mg. per cent, the basal metabolic rate plus 20 per cent, Wassermann test and complete blood count normal.

Phenobarbital, 0.03 Gm. ($\frac{1}{2}$ grain), 4 times a day was prescribed.

Returning January 11, 1944, she reported no relief. The blood pressure was 160/90. Ten-inch blocks were advised.

The patient returned 1 year later. She had been using only 5-inch blocks, being unable to sleep with more elevation. The headaches were still waking her between 2 and 6 a.m. and recurred in the evening but of less severity. The blood pressure was 145/90. On May 2, 1945 her complaint was unchanged. The blood pressure was 170/90. One ergotamine tablet 4 times a day for 1 week was prescribed.

The patient returned May 23, 1945 and had made considerable improvement. Headaches were not recurring in the evening, and the morning pain lasted only 1 or 2 hours. She had also been able to sleep through the night without the headache awakening her. The blood pressure was 168/80.

She reported back on June 18, 1945. The morning headaches were still present only 2 or 3 times a week and of about 1 hour's duration. Intermittent frontal aching was present during the day. The blood pressure was 150/90. Two ergotamine tablets after each meal and at bedtime were prescribed. This was double the previous dose. Four days later the patient reported complete relief from headache. The blood pressure was 160/100.

She was told to reduce the dose of ergotamine to 1 tablet (1 mg.) 4 times a day. On August 1, 1945 the patient was having a very occasional headache during the day. Morning headaches were still present 2 or 3 times a week, and she was able to sleep through the night. More elevation of the head of her bed was urged. The blood pressure was 170/100.

The patient returned August 7, 1945, having only morning headaches. These were relieved half an hour after being out of bed. Ergotamine was discontinued. On August 18, 1945 morning headaches had persisted but the patient was able to sleep through the night. She had been unable to rest with any further elevation of the head of her bed. During the day she was not having headaches. The blood pressure was 180/100.

Case 11.—C. W. (No. 36359) The patient was a negress aged 53 years. She was admitted to the clinic, April 25, 1945, complaining of a dull, heavy ache in the vertex of the skull. This pain waked her up about 9 a.m. Getting up relieved it and it wore off in an hour or so, to recur in the evening. The onset had been 10 years before. Attacks of vertigo associated with headache had been present for the past year. The patient never before suffered headache nor is there any family history of headache. High blood pressure had been discovered in Au-

gust, 1943. Menopausal symptoms had been present for 1 year. The blood pressure was 220/100. Fundoscopic examination revealed A-V nicking. Early cardiomegaly was present.

The cold-pressor test was negative. The basal metabolic rate was plus 8 per cent, the blood cholesterol 200 mg. per cent, and the nonprotein nitrogen 24 mg. per cent. Urinalysis showed a very faint trace of albumin; the complete blood count was normal, and the Wassermann test was negative. Roentgenogram of the chest showed mild cardiac enlargement.

Returning on June 6, 1945, the patient reported no improvement in her symptoms. The blood pressure was 240/100. Ten-inch blocks were prescribed. On June 13, 1945 she reported complete remission of the morning headaches. The blood pressure was 240/120. Digitalization was instituted. One week later the patient was still sleeping with her head elevated and had experienced no morning headaches. The blood pressure was 250/130. On July 11, 1945 she reported no recurrence of headaches. The blood pressure was 225/120. She was told to remove the blocks from under the bedposts and to report back when she had a recurrence of headache.

Case 12.—M. H. (No. 34079) The patient was a colored female aged 53 years. She complained of dull, heavy, frontal aching, beginning 10 years before. Increasing severity of the headache had been noted for the preceding 2 weeks. Two or three headaches each week for the past 2 weeks had been present. The cephalalgia had been present on awakening, to disappear after being out of bed for one or two hours. Nervousness or overwork caused recurrence of pain during the day. Hypertension had been discovered 10 years before. Physical examination revealed only a blood pressure of 165/90. Basal metabolic rate, blood nonprotein nitrogen, blood cholesterol, and Wassermann and Kahn tests were all normal. Urinalysis showed a faint trace of albumin. Pressor and hyperventilation tests were positive.

Four-tenths of a c.c. of ergotamine tartrate given intravenously relieved the frontal aching. Ten-inch blocks were prescribed. On May 4, 1945 the patient reported no relief. The blood pressure was 180/100. One milligram ergotamine tablets 4 times a day were prescribed for a week. On June 21, 1945 she reported complete remission of headache. The blood pressure was 160/100.

The patient returned, July 30, 1945, with no recurrence of her headache. She had never used blocks as instructed but had elevated her head on 2 large pillows. The blood pressure was 170/95.

The site of action of ergotamine is directly on arterial smooth muscle causing contraction.

Ergotamine (trade name Gynergen) produces constriction in the excised artery.¹⁹

From the small series of cases it appears to be most efficacious.

COMMENT

Twelve cases of headache associated with hypertension worked up in the George Washington University Hospital Outpatient Department have been treated with elevation of the head of their bed during sleep.

Ten of the twelve patients obtained dramatic relief of their complaint. Four patients required oral ergotamine therapy and obtained complete relief after a week's course of medication.

In only 1 case was there partial failure. This patient (case no. 10) was unable to sleep with more than 5-inch elevation of the head of her bed.

Nicotinic acid was prescribed in several cases on the hypothesis that this headache, like migraine, is a primary vasoconstrictor type. It was of no value.

Phenobarbital and thiocyanates were used prior to institution of the present therapy. These modalities were also ineffective.

CONCLUSIONS

This mode of therapy is based on correlation of a symptom of essential hypertension with disturbed physiology.

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THE SURGICAL TREATMENT OF VARICOSE VEINS

("Retrograde Catheter Method")

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THE surgical treatment of varicose veins is not only a rational but also an economical solution of the problem. Properly executed, it usually entails no loss of time to the patient and also gives, in competent hands, eminently satisfactory results. Out of the numerous methods devised by the pioneers in this field, it is my experience that the retrograde injection of the sclerosing agent with a ureteral catheter following saphenofemoral ligation is the most satisfactory.

This paper is intended primarily to give the detailed description of the technic, with no attempt to review the literature nor to delve into the theoretical aspect of the problem since it already has been a subject of discussion by many distinguished contributors.

Practically every case of incompetency of the valves, with secondary dilatation and tortuosity of the superficial venous system, is suitable for this procedure. The only absolute contraindications are the presence of generalized infection, active thrombophlebitis, or complete incompetency of the deep venous circulation. Even the last, in view of the classical contributions of Dougherty and Homans,¹ may have to be reconsidered.

The diagnostic procedures for syphilis and diabetes must be carried out on every patient. Although neither of them is a contraindication, it does assume an important role in the presence of ulcers. Diabetes especially warrants attention. Unfortunately, it is all too frequent, particularly in adipose individuals. The urinalysis, in most cases, should suffice, although in doubtful cases the study of the blood sugar is in order. Should it prove to be more than

180 in the fasting state, the use of insulin should be seriously considered. Varicose ulcers in the presence of syphilis are likewise not a contraindication, provided the individual is undergoing antiluetic therapy. In any case of ulceration the patient can no longer be considered a strictly ambulatory case but should be kept in bed for a few days following the operation.

The competency of the deep venous circulation is confirmed by the Perthes' and Brodie-Trendelenburg tests. The Perthes' test is carried out as follows: "A tourniquet is applied on the patient's thigh, tightly enough to compress the internal saphenous vein and prevent the flow of blood in the superficial system past this constriction. The patient then walks and the prominence of the vein is noted. If, because of compression by the tourniquet, the blood cannot return by retrograde flow through the superficial veins whose valves are incompetent, the varicosities improve when the patient walks provided communicating veins and deep veins are patent."

We can do no better than to quote verbatim the words of Brodie-Trendelenburg in describing their method: "The patient lies down and elevates the leg, and the veins empty. When the patient now comes to the sitting position, the saphenous vein fills rapidly with blood. If the procedure is repeated except that with the leg in the vertical position the finger is pressed and held over the stem of the saphenous vein, then when the patient assumes the erect position the varices fill very slowly; but if the finger is suddenly released, the veins rapidly distend to their former size."

TECHNIC

The procedure is best carried out in a hospital, although a properly equipped office may also be satisfactory, since in every surgical procedure in which the vascular system is involved complete asepsis is essential. The instruments have to be of the best possible quality, because, as

individual, by 0.01 Gm. ($\frac{1}{6}$ grain) of morphine gives desired results.

The area around the pubis extending to the mid-thigh must be scrupulously shaved and sterilized, preferably by a nonirritating antiseptic. I prefer tincture of Mercresin to iodine, since iodine not infrequently produces local irritation of the skin which delays healing.

The patient is placed on an operating table in the most comfortable position for each individual case. Most patients prefer 2 pillows under the head and 1 small one at the base of the spine. Another smaller pillow or a sandbag is placed at the bend of the knee. The leg and the thigh are everted to the maximum and placed in abduction by about 20 degrees. For local anesthesia, 1 per cent novocaine solution without adrenalin is used. The anesthetic is first administered by a small hypodermic needle starting at the outer angle of the iliac crest. This is replaced by a $1\frac{1}{2}$ inch, 22-gauge needle, and the entire area from the inguinal region



FIG. 1. Technic of "retrograde catheter method."

has been pointed out by McPheeters,² hemostats with teeth have a tendency to tear the structure, favoring oozing with possibly a small hemorrhage. Preoperatively, the patient may require slight sedation, although in many cases it is not necessary. In my experience a barbiturate such as Nembutal or Seconal (0.1 Gm. or $1\frac{1}{2}$ grains) taken 1 hour prior to the operation and supplemented, in the case of a nervous

down to about 3 fingerbreadths below the inguinal fold is thus infiltrated. It is essential to allow at least 3 minutes before the actual start of the operation, since the maximum effect of the anesthetic is not, as is frequently assumed, immediate.

The incision, which never has to be longer than 2 inches, is made 2 fingerbreadths below the inguinal fold (fig. 1). There is usually

practically no bleeding. The moment the fatty tissue is encountered the scalpel is replaced by a hemostat which is used for the blunt dissection. The saphenous vein, except in very adipose individuals, is reached at the depth of $\frac{1}{2}$ inch. The moment it is visualized, the hemostat is replaced by fingers covered by gauze, and with these the vein is separated from adjacent tissues. It is not desirable to clean the vein by pushing the tissues upward, since occasionally such manipulations may lead to the formation of a thrombus. An aneurysm needle is then placed under the vein and the vein is thus elevated. At this moment most of the patients complain of a sense of tugging, but no actual pain is elicited. A clamp is then placed at the most proximal portion of the vein and by applying gentle traction it is possible to separate the vein further from its bed. The branches that are brought into view have no constancy of distribution, and the operator has to be guided mainly by his eyesight. Classically, the tributaries of the internal saphenous vein are the superficial epigastric, the external circumflex iliac, the external pudendal, and the external superficial femoral. They are all transfixed and ligated by no. 1 or no. 2 silk suture. After the ligation is accomplished, the assistant applies traction on the clamp and a $\frac{1}{4}$ inch, longitudinal incision is made in the internal saphenous vein by a small sharp-pointed scalpel. Application of traction eliminates any spurting or loss of blood. A ureteral catheter is then introduced into the vein. Care should be taken to assure its entry into the orifice. Not infrequently the catheter, by mistake, enters into a fibrous sheath of the vein. Since it passes easily in either case, it is desirable to aspirate in order to be certain of its position. The appearance of blood is an evidence that the catheter is in the right place. The catheter usually passes without any difficulty as far as the knee. There some difficulty is encountered, possibly due either to the valve or to the bifurcation of the vein. By slight up-and-down manip-

ulation this may be overcome and the catheter may be introduced as far as the ankle. This having been accomplished, a single-knot ligature is placed over the vein somewhat below the incision in order to stabilize the catheter. The next step is to place a piece of gauze under the incised portion of the vein. This is an essential step, because when the catheter is withdrawn subsequent to the injection the tissue underneath must be protected against coming in contact with the sclerosing fluid. Most of the painful reactions following this operation are due to this avoidable accident.

A syringe is then filled with the sclerosing agent and attached snugly to the catheter. Here, again, a tight ligature is most helpful. It has been my experience that the best results are obtained with 50 per cent glucose solution. It seldom produces any adverse systemic effects, while retaining all the qualities of a sclerosing agent. Other excellent preparations of various sorts are available on the market, but they are frequently responsible for a systemic reaction. In the case of 50 per cent glucose, as high as 50 c.c. can be injected with impunity. The injection is carried out, with the assistant slowly withdrawing the catheter. During the injection, it is essential that slight traction be applied to the ligature supporting the catheter in its place. The patient makes no complaint as long as the injection is carried below the knee. When the catheter is withdrawn as far as the knee joint, the patient always remarks about either a burning or stinging sensation. The moment the catheter is withdrawn, the knot is tightened and reinforced by application of a smooth hemostat. Another clamp is placed well below the incision, the vein is then transfixed by double silk ligature proximally and distally, and the segment is removed. The wound is then irrigated with warm saline solution and is closed by interrupted silk sutures, following several subcutaneous ligatures. The wound is dressed with dry gauze and elastic adhesive. It is

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A TRANSVERSE INCISION FOR GALLBLADDER SURGERY

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NO CHANGE any established surgical procedure is not something to be undertaken lightly, but surely we should strive to lessen the seriousness of all operations. The shortening of convalescence is a goal worthy of any surgeon's endeavor, even at the cost of being branded as unorthodox in method.

Postoperative hernias are more common than we care to admit, and inoperable postoperative hernias not only are plentiful but are very distressing, both to the person having one and to the conscientious surgeon. Large incisions are necessary for some operations, but why make them for all cases? The large incision prolongs the convalescence, increases the patient's discomfort and causes more adhesions. In fact, it is nearly impossible to close a large incision without causing the omentum to adhere its entire length. Then, why not let the individual skill determine the length of the incision without any stigma being cast upon one who strives to reduce to the least magnitude most ordinary operations?

We believe that the incision to be described is ideal in operating for gallbladder disease, perforated ulcer and stenosed pylorus in infants. Our morbidity in these cases has been lessened to a surprising degree by its use. A study has been made of the first 100 consecutive gallbladder operations done through this incision; the first one was done on September 13, 1944, and the 100th on June 28, 1945. Of these, stones were found in 79 and not found in 21; 40 cases were acute and 60 chronic; there were stones in the common duct in 7, although the

common duct was explored in a large per cent of the cases. The ages of the patients ranged from 9 years to 83 years. There were 3 deaths: one the case of a male 74 years of age, having cardiac or pulmonary complications; another

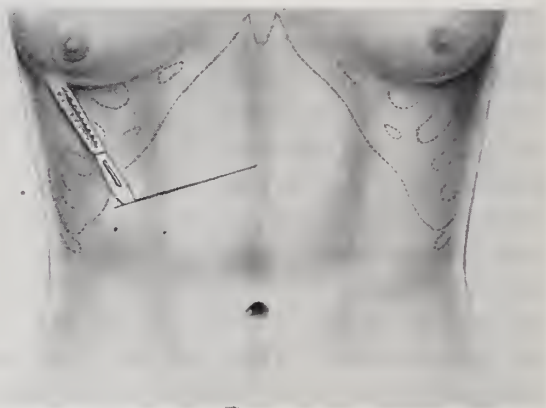


FIG. 1. The skin incision.

that of a female 72 years of age with cancer of the gallbladder and metastasis; and the third the case of a female 39 years of age, who in addition to having an acute, suppurative, calculous cholecystitis had a toxic thyroid of long standing and with an associated cardiac weakness.

The physiologic principles which make the transverse abdominal incision preferable to the longitudinal incision have been enumerated many times. Clinically, the chief advantage of the transverse incision is directly related to the postoperative comfort. This "comfort" factor would seem to be easy of explanation. A transverse incision tends to close naturally. The patient may sit up very early because

flexion of the hip decreases rather than increases strain on the wound. Any postoperative distention puts much less strain on the transverse incision than on the longitudinal one. Patients resist deep breathing much less, and the postoperative pulmonary complications are, we believe, remarkably lessened.

that of the rectus muscle, was divided transversely. Narrow blade retractors were used to expose the gallbladder which was removed from above downward. Drainage of the gallbladder bed was practiced routinely. The drainage tube was allowed to emerge through the primary incision. This drain was removed

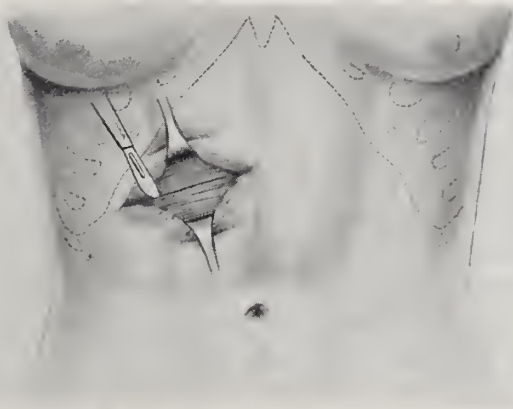


FIG. 2. Transverse incision of anterior sheath of rectus.



FIG. 3. Separation of rectus muscle fibers longitudinally with knife handle.

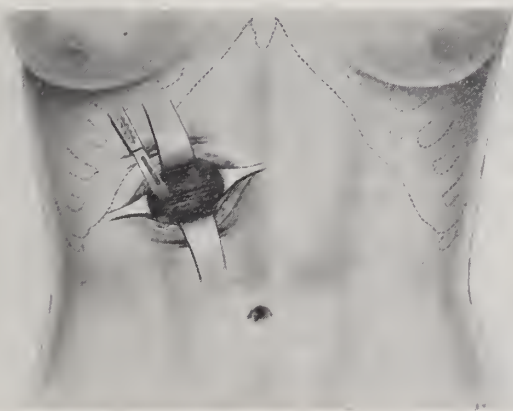


FIG. 4. Transverse incision of transversalis fascia and peritoneum.



FIG. 5. Exteriorization of gallbladder.

In most clinics the transverse incision utilized frequently for gallbladder surgery has called for the transverse division of the skin, anterior rectus sheath, rectus muscle, posterior rectus sheath and peritoneum. In this series of 100 consecutive cases the same incision has been used with the modification that the rectus muscle was split longitudinally, parallel to its fibers (figs. 1 to 5). Each tissue layer, except

after a few hours if there was no bile drainage.

An early rising routine was practiced for all patients. The procedure was to elevate the head of the bed as soon as the patient had reacted from the anesthetic. The elevation was maintained until the patient became tired. On the first postoperative day the patient was set up with legs over the side of the bed. Unless there was an unusual amount of bile drainage

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THE CAUSALGIC STATE: EARLY AND FIXED LESIONS

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C AUSALGIA, a painful complication of wounds, is described under many names. Neurotrophic state, Sudek's atrophy, and other neurocirculatory disorders are varieties of the same condition. It is believed by many that this condition is the cause of all such wound manifestations, from the painful appendix scar to the amputation stump. This process has long been known but has been studied extensively only in the last 10 years. By the very nature of things interest in the condition is stimulated during and after wars. Causalgia was named and first described during the Civil War (1860-65).¹ After the first World War the condition aroused considerable interest, but the mechanism was then unexplained. During this War it has been the privilege of many of us serving in the military service overseas to observe the disease in its incipency. Well developed lesions now are being seen not uncommonly in military hospitals. Industrial surgeons have always been troubled with an occasional variety of the process.²

Burning pain of an extremity with dull muscle ache and paresthesia of the glove or sock type are the characteristics of the disease early in its course. Here the loss of sensation of light touch only is at times a diagnostic feature, for the hysteric and malingerer usually show greatly amplified or absent sensation. As the disease progresses one sees atrophy of disuse as these people discontinue the use of the part due to pain. Brawny edema, cyanosis or pallor, and glossiness of the skin are later changes. Osteoporosis is demonstrable in X-ray films and appears from 8 to 12 months following injury. This is greatly in excess to that expected from disuse. In progressive

severe lesions the pain becomes unbearable, leading to tractotomy or amputation.

The condition as seen in a very early state is difficult to separate from the neuroses. This was particularly the case in the soldier who had recently been in combat. The wish to defer return to the front frequently caused the soldier to complain of excessive wound pain. Sympathetic nerve block was useful, because the procedure relieved or cured causalgia, but it did not affect cases with central nerve damage and invariably made the neurotic worse.¹ As the process becomes fixed, the effect of procaine block tends to show a progressive decrease in efficacy. In well developed cases, as will now be seen, trophic changes attest definite residuals. At this stage hysteria and mental changes are a result of causalgia rather than a cause.³

Moser⁴ has described a perivascular lymphangiitis ascending from the original wounds in cases of causalgia, and he believes this process disturbs the sympathetic nerves running with the vessels from these wounds. Ultimately he feels the metabolism of the whole peripheral nerve supplying the part is affected. Seddon⁵ believes the increasing trickle of reports on causalgia in the German literature indicate a much larger incidence of the disease in the German army than in the British. Although statistics are not available, he feels the lower proportion of infected wounds among the British accounts for this phenomenon. Certainly the adequate wound care received by the American forces has contributed to the low incidence of the disease as seen in our Army. The usual history of a case of causalgia reveals the wound to have apparently healed per primam, and later exploration of the wounds has never given

good results, since the trauma apparently causes the occult infection to flare up and increases the sympathetic activity.

The development of causalgia is divisible into 2 stages: (1) an early disorder of increased activity of the sympathetic nervous system such as has been well described by deTakats,⁶ Pfab and Raffler,⁷ and others, and (2) the progression of this condition into a fixed irreversible involvement of the peripheral nerve, metabolic in nature. These stages are represented clinically by, first, a recently healed wound on a painful extremity which is relieved by sympathetic interruption, and, second, a clearly damaged part showing trophic changes, usually beyond help by sympathetic procedures.

That the effect of interruption of the autonomic pathways is beneficial in early causalgia has been shown by all workers. Indeed, this effect is one of our few proofs that the entity is caused by an abnormal autonomic system. In a prior publication¹ the effects of sympathetic block on causalgia were reviewed in cases seen shortly after healing of the initial wounds during the Italian campaign. Similar results have been reported elsewhere. As Seddon says, the Germans seem to have led the field in these studies.

Speigel and Milowsky³ report 9 cases benefited, with 1 of their cases showing the fixed stage of osteoporosis. However, all of their cases were treated within 1 year of the original injury. I saw 2 cases in 1945 of mild degree, both patients being wounded early in 1943. Although paravertebral block produced increased heat and cessation of sweating of the affected extremity, neither patient showed relief of the characteristic ache and burning pain in the slightest.

Even though good results of sympathetic block are not to be expected routinely in fixed cases, the procedure affords prognostic value, and from the report of Speigel and Milowsky an excellent result may at times ensue. The

simple procedure of procaine paravertebral block, being safe and relatively painless, is seldom contraindicated.

Surgical ganglionectomy is reserved for those cases showing only transitory improvement to procaine block. When no benefit is obtained from procaine, only bad results are to be expected from ganglionectomy. The use of alcohol injection is coming into discard, since unfavorable pain from the injection occurs at times. This procedure is uncertain and ganglionectomy assures a more certain and permanent result. The more formidable procedures of tractotomy and amputation will probably be necessary in some cases.

SUMMARY

1. Causalgia is considered to be the cause of excessive symptoms after the healing of most wounds and injuries.
2. The effect of sympathetic interruption is beneficial in early cases.
3. In fixed cases the involvement of peripheral nerves renders sympathetic block of little or no value.

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President's Page

WHERE WE DIFFER

A week has passed since President Truman sent his five-point National Health Program to Congress. I have read it twice, and to me his aims are very much in line with our own. Where we differ is in the way it shall be accomplished.

We believe that when a community gets together and works for a hospital, or works for a health program, they are more interested in it and it is apt to be run better than if it is administered by the Government. Many states already have prepaid medical care plans in successful operation, and these plans are becoming better all the time, but they are worked out the American way, on a voluntary basis. I think the medical profession is trying very hard to have clear vision and to be unselfish in formulating a national plan, but I am sorry to say that this plan was not ready to be put before the public before President Truman sent his message to Congress.

Perhaps President Truman feels that his plan is not related to "socialized medicine," but when his bureaus get organized for the administration of the plan, and when hospitals and research institutions are loaned Government money, I wonder how much voice we of the medical profession will have, or even how much voice the laity will have in the working of the plan.

The whole idea is tremendous in its ramifications, and it would seem as though the plan should be tried if possible on a voluntary basis, and on a smaller scale, and then when it is perfected let it be made national in scope.

I am under the impression that President Truman's plan would cost the country an initial outlay of some four billion dollars. With the Nation already staggering under an incredible load of debt, is it wise to embark on a program that has not been proved to be sound and workable?

Wm. Earl Clark

Editorials

THE CHRISTMAS SPIRIT

One cannot write about Christmas without becoming sentimental for there is no holiday of the year which brings back so many happy memories. Our closest associations are bound up in the celebration of the birth of Christianity.

Life at its very best is often disillusioning. Our hopes rise to great heights only to be shattered by disappointments. However, it seems that this commonest of human experiences makes little impression on most of us. We are by nature incorrigibly optimistic. A recent example is the confidence with which we anticipated a perfect peace at the close of the most recent and greatest of wars. Now we find it is far from perfect. In fact, there is no peace. Although we have laid down our arms, war still plagues the peoples of the earth. For that matter, the threat of war still hangs over our land due to the development of the awe-inspiring atomic bomb. As if this were not enough, in our own country there are violent clashes between capital and labor. Greed and selfishness, it seems, are blemishing the happy postwar period that we fought and prayed for.

Into this turbulent atmosphere comes the gentle spirit of Christmas. Somehow human beings, no matter how calloused they may be, are softened by it. Would that it could continue

throughout the coming year. Its quieting influence, its sense of assurance would do much toward bringing peace to us at home and abroad. Assuredly, the only hope of humanity lies in the inculcation of this spirit in the peoples of all the earth.

Many of us have much to be thankful for this Christmas. Our boys are home, our families intact. Necessities of life are ample for us in America. But let us not forget that there are those who are far less fortunate. Many have lost loved ones in the service of their country. Theirs will be a lonely Christmas. Millions of people in Europe and other lands are literally on the brink of starvation. If the Christmas spirit means anything, it means that we will remember them in a practical way, bringing them the necessities of life. There are disturbing conditions in political and economic spheres. Here, too, sympathetic understanding would prove a great palliative.

Yes, it is difficult to talk about Christmas without becoming sentimental. Nevertheless, it would appear that unless the spirit of this season becomes universal, there is little hope for the world.

T. W.

ACUTE HEPATITIS

The prevalence of acute hepatitis among troops and the serious incapacitation it produces have brought considerable attention to this interesting condition during World War II. In military experience there have been chiefly two

forms of acute hepatitis: infectious (epidemic) hepatitis and homologous serum jaundice. The relationship of these two forms to each other and to cases of acute catarrhal jaundice and "idopathic" hepatitis seen in civilian practice has

been the subject of much discussion but is still unsettled. From the clinical point of view there is no important distinction in the manifestations of these various forms of hepatitis, but this is no assurance that the cause is the same in all cases.

In the case of both infectious hepatitis and homologous serum jaundice the causative agent or agents are filtrable (virus?) and relatively resistant to heat. There are, however, important epidemiologic differences in the two conditions. These have been investigated mainly by means of transmission experiments using human volunteers. Serum jaundice is essentially an artificial disease in that the agent causing hepatitis is transmitted to humans in injections of homologous serum given for any purpose. The largest group of cases followed the use of a yellow fever vaccine containing human serum. The agent remains in the blood of the recipient for a long time during the incubation period and during the course of the disease. The causative agent of infectious hepatitis, in addition to being present in the blood of the patient, is found in the feces during the disease. It has long been suspected that the intestinal-oral method is important in the transmission of this disease, and this idea has been supported by the studies of Neefe and Stokes¹ in connection with a civilian epidemic. The incubation period of infectious hepatitis is considerably shorter (2 to 4 weeks) than that of serum jaundice (2 to 4 months).

The opportunity to study acute hepatitis in large groups of patients has emphasized certain clinical features. It is clear that acute hepatitis is not always a benign illness of brief duration. It may rarely pursue a fulminating course to death; recurrences are not rare; subclinical liver disease may persist for a long time after the jaundice has subsided; and, in the case of infectious hepatitis at least, there may be serious clinical sequelae. In connection with this last consideration, Benjamin and Hoyt² have re-

ported that in a group of 200 patients with prolonged convalescence after homologous serum jaundice, there were thirty-seven (18.5 per cent) who manifested a curious "tremor syndrome." They exhibited icy, red, wet extremities, constant pronounced tremor which became aggravated with exertion, and extreme weakness. In addition, in 20 of these patients there was mask-like facial expression and lack of free swing of the arms in walking. In the course of clinical studies of acute infectious hepatitis, Barker, Capps and Allen³ discovered that certain patients failed to recover promptly, retaining evidences of active liver disease for long periods of time. The symptoms of this form of "chronic hepatitis" for the most part are vague though incapacitating. Of considerable importance in the diagnosis is the tendency of symptoms to be aggravated by exercise. The liver remains enlarged and tender, and the enlargement increases promptly with physical exertion. These patients have usually improved quickly with meticulous supportive treatment, especially strict rest, but the eventual prognosis is still unknown.

There have been various contributions to the treatment of acute hepatitis of which two are especially noteworthy. Barker and his co-workers^{3, 4} have emphasized that complete rest is essential during the period of activity of the disease. Disregard of this fact may considerably intensify symptoms or even provoke relapse. Restoration of the patient to activity should be gradual, with close attention to the "exercise tolerance" as measured principally by the effect of exercise on the size of the liver. The other therapeutic point concerns the use of injections of gamma globulin for the prevention or attenuation of infectious hepatitis. Stokes and Neefe⁵ first suggested this method and reported its effectiveness. Since this report was published,

³ Barker, M. H., Capps, R. B., and Allen, F. W.: *J. A. M. A.*, 1945, **129**, 653.

⁴ Barker, M. H., Capps, R. B., and Allen, F. W.: *Ibid.*, 1945, **128**, 997.

⁵ Stokes, J., Jr., and Neefe, J. R.: *Ibid.*, 1945, **127**, 144.

⁶ Gellis, S. S., and others: *Ibid.*, 1945, **128**, 1062.

⁷ Havens, W. P., Jr., and Paul, J. R.: *Ibid.*, 1945, **129**, 270.

¹ Neefe, J. R., and Stokes, J.: *J. A. M. A.*, 1945, **128**, 1063.

² Benjamin, J. E., and Hoyt, R. C.: *Ibid.*, 1945, **128**, 319.

Gellis and his co-workers⁶ and Havens and Paul⁷ have independently verified that injections of gamma globulin are effective in preventing

infectious hepatitis when given during the incubation period of the disease.

H. H. H.

CIVIC ORGANIZATION SEEKS TO IMPROVE COMMUNITY HEALTH

According to its by-laws, the Board of Trade's objective is the consideration of, and action upon, matters pertaining to the welfare of the Nation's Capital. It follows therefore that the Board's interests are diversified and its membership represents nearly every phase of life in the Nation's Capital.

The Board's membership, which now numbers more than 6,000, comes predominantly from the business community, but contains sizable groups from most professional fields, and the Federal and District governments. The scope of its activities is shown by the names of some of the standing committees. There are committees on public health, welfare, parks and recreation, public schools, and American ideals.

It might be said that the Board of Trade's primary objective is to make of Washington the best place in the world in which to live. For its efforts are devoted first and foremost to making the community sound and stable economically. To that end, the Board has been extremely active over a period of more than half a century. Positive steps have been taken to insure the greatest possible centralization of the Federal establishment in this city. National organizations such as trade associations, labor groups, and professional societies have also been encouraged to open offices in Washington.

The visitor in the Nation's Capital looms large in Washington's economic affairs, and the Board, through its Greater National Capital Committee, in normal times maintains one of the largest convention bureaus in the country. An expert staff of men is constantly traveling through the United States to bring conventions and tourists to the city. Before the war they numbered about three and one-half million a year and spent an estimated \$60,000,000

annually with Washington's hotels, restaurants and stores.

Statistical information is gathered, developed, coordinated and made available to the Board's members and the community in general. Examples of the excellent work that has been done in this field are the recent reports of the Postwar Planning Committee which chart Washington's population and employment possibilities through the next five years.

Due to the absence of the usual means of securing the expressions and opinions of residents, the Board of Trade plays an extremely important part in respect to all legislation affecting the District of Columbia. On the economic side, the Board is intensely interested in the annual municipal budget and in all matters of tax and regulatory legislation. There can be no question of the fact that the Board has done more original work with regard to revenue sources, tax administration, and municipal finances than any other non-Governmental agency in the city. The Board is particularly proud of its many successful campaigns to save the taxpayers of the District of Columbia many millions of dollars. Its most recent activity in this connection was the three-year effort to secure a reduction in the Unemployment Compensation Tax. Since the law was amended two years ago, it is estimated that employers in the District of Columbia have been saved between six and seven million dollars annually in payroll taxes.

But the Board has also shown a deep and continuing interest in other phases of community life designed to make this the best city in which to live. In the field of health, the Board of Trade has for many years endeavored to better

the health of the citizens of the District of Columbia. Through its Committee on Public Health and its subcommittees, many specific problems have engaged its attention.

The costs of medical care and hospitalization in the Metropolitan Area, the apportionment of physicians per capita during wartime, provision for care of patients during epidemics or disaster, the Civilian Defense Program, and many other matters have engaged the attention of this Committee. Proposed legislation pertaining to the practice of the healing arts in Washington has been studied and recommendations made. There has been the closest coöperation with the District Health Department. Its activities have been supported and at times severely criticized in the hope of attaining substantial improvement.

By some the Medical Society of the District of Columbia may be thought to be primarily concerned with the welfare of its members. However, its interests are far broader in scope and include all aspects of medicine—scientific, social and economic. The Society has for several years been one of the most progressive in the country. It is natural then that the Board of Trade and the Medical Society should have much in common. Members of the Society have headed the Public Health Committee of the Board for more than a decade. They

have also been active as chairmen of the various subcommittees.

One of the ablest was Dr. Arthur C. Christie, Chairman of the Board's Committee on Public Health from 1934 to 1940. His knowledge of medical economics and social problems was of the greatest value. Under his direction the Committee laid a sound foundation for its future activities.

The Board's Committee on Public Health was the first body to endorse the current Health and Hospital Survey within the Metropolitan Area.

Organizations which have coöperated with the Committee in its program are the Council of Social Agencies, the District of Columbia Dental Society, the Instructive Visiting Nurse Society, the District Pharmaceutical Association, District Chapter of the Red Cross, the District Social Hygiene Society and the District of Columbia Tuberculosis Association.

As every one is aware we are in an era with rapidly changing needs, many of them urgent. The Medical Society is expected to take a strong lead in keeping pace with changing needs. The Board is earnest in its desire to do the same thing. Where health is concerned our hope lies in the continued strength of the Medical Society and its coöperation with civic organizations.

ROY LYMAN SEXTON, M.D.

TUBERCULOSIS CONTROL IN THE DISTRICT

Tuberculosis, long one of the District's most pressing public health problems, today is acute. This in face of the fact that almost half of the Health Department's yearly appropriation goes for tuberculosis prevention, control and treatment.

The chief causes of this quite desperate situation are a shortage of beds, resulting from lack of hospital personnel, and the need for more accurate and up-to-the-minute tuberculosis records.

As for the first cause, it should be removed by reclassification of vacant jobs upward as to salary, so that applicants would be attracted to them. It is inconceivable to expect the employment of graduate nurses required to have extensive training and experience at the salary now offered. It does not seem reasonable that these vacancies will ever be filled at this wage rate so long as nursing positions are vacant in nearby Maryland and Virginia at higher salaries. Because of the critical shortage of hospital beds,

the District limits admission of tuberculous patients to only those in the most advanced stages. Thirty-seven per cent of all tuberculous patients admitted to Gallinger Hospital die within 30 days. One hundred and fifty-seven moderately advanced and far advanced cases now are awaiting hospitalization, many of whom have been on the waiting list for four or more months. It is a pity that hospital facilities are not available for hundreds of early cases of tuberculosis, which could be arrested in a shorter period if allowed hospital care. These, unfortunately, are not even carried on hospital lists because there are no beds in which to hospitalize them.

As for the second cause, information concerning the actual cases of tuberculosis in the District is in a very unsatisfactory state. Many cases are not reported until the time of the patient's death. Many are not diagnosed until

late in the course of the disease. Failure to diagnose may be due in some instances to the fact that the disease is not recognized by the physician or perhaps because the patient postpones medical consultation, or both. The recently established Central Case Register should reveal the condition of the tuberculosis population at any given time. However, an analysis of the records of the register brings to light the pressing need for complete case-reporting and intensive follow-up care.

The postwar period must not find us so remiss. While many parts of the present tuberculosis program are excellent, what it requires is overall coördination and the adoption of more aggressive attitudes.

EDWARD K. FUNKHOUSER

*Executive Secretary, District of Columbia
Tuberculosis Association*

In and Out of Focus

BY THE OBSERVER

The Man Behind the Desk Physicians need speculate no longer on President Truman's political views where medicine is concerned. His message to Congress outlining a national health program was a bombshell to physicians who thought that the President was at heart a conservative. Far more bluntly than his predecessor, he urged the need for a compulsory health insurance system. Curiously, his message had greater public appeal than any statement on the subject by the late President Roosevelt. For there was much common sense in it and with most of it even physicians could not disagree. If doctors read the controversial compulsory health insurance section of the President's message objectively, they will understand why the average citizen sees little objection to it except its cost. As a matter of fact the

more intelligent of our citizens have long supported the view that there are serious deficiencies in the distribution of medical care and that somehow they must be remedied.

Certainly one of the most regrettable factors in this situation has been the A.M.A.'s lack of leadership. Not until very recently has there been evidence of the Association's awakening to its social responsibilities. It now remains to be seen if it is a case of "too little and too late." That may be determined before these lines appear.

The fact that President Truman did not see fit to consult with leaders of organized medicine about his plans should be cause for deep concern. If there had been any question as to their standing with the President there need be none now. In fact, your Observer has it on pretty good

authority that leaders of organized medicine are *personae non gratae* at the White House, and it is not likely that there will be any change in attitude.

The President, it will be recalled, made a point of the fact that the compulsory health insurance system he proposed is not "socialized medicine." "Socialized medicine," he says, "means that all doctors work as employees of government. The American people want no such system. No such system is here proposed." He assures the people that there will be free choice of physician by patient and vice versa and, he says, "Under the plan I suggest, our people would continue to get medical and hospital services just as they do now—on the basis of their own voluntary decisions and choices."

No one, least of all your Observer, doubts the President's sincerity. He undoubtedly believes that there will be no change in the present system of medical care except that physicians who decide to participate will be paid for their services from a Government-controlled insurance fund. What the President overlooks, of course, is that no system can operate without controls. Should an attempt be made to do so abuses would be followed by regulations to curb unfair practices on the part of both patients and physicians. If experience with compulsory systems abroad is any criterion, restrictions will pyramid and become more objectionable the longer the system is in operation.

The President says that physicians can participate in the program or remain outside of it, carrying on their private practices as heretofore. However, physicians will really have little choice. If a sufficient number of their patients decide to come under the program, they will find it greatly to their disadvantage not to participate. Eventually, to protect their interests and make a living, they will have to become insurance physicians.

Now all of these arguments, important though they are, would not be sufficient to condemn the President's program. There is one factor in the situation which is disturbing and should concern the citizen as well as the physician. That is the

spectre of the bureaucrat. Gradually in such a system, there will emerge The Man Behind the Desk, the official whose task it will be to see that the interests of the Government are protected. It is this man whom a free medical profession fears. His influence will filter down through the whole medical system. What evidence is there of this danger? The President endeavors to allay fears by stating that "Medical services are personal. Therefore the nation-wide system must be highly decentralized in administration." However, he also says that "Subject to national standards, methods and rates of paying doctors and hospitals should be adjusted locally." In other words, the system will of necessity operate according to a plan devised in and directed from Washington.

Gould Lincoln, *Evening Star* (Washington) columnist recognizes this possibility when he writes:

"While the program now advanced may at the outset not be 'socialized medicine' or 'political medicine,' as the President and Mr. Wagner assert, there is no assurance it will not become so. How far and how long can the practice of medicine exist half private and half Government? The Government in competition with private medicine in all probability can have only one result—eventually it will be all Government medicine.

"Mr. Wagner insisted that there will be a free choice of physicians made by the citizens—and at the same time that the physicians will have the right to take what patients they wish. There is violent conflict in the two ideas. If there is Government medicine in the end, the citizens will take medical services from those physicians to whom they are assigned.

"The Government can provide aid in the construction and equipment of hospitals so that there shall be enough to care for the people who need hospital treatment, and that has been proposed in other measures as well as in the Wagner Bill. It can provide money for medical research—and it does now in the Public Health Service to some degree. But whether the Government should undertake to provide medical services for all the people is another matter. It may lead to regimentation and political appointments and to the employment of a great number of administrative agents."

Those who would minimize these arguments may point to the workmen's compensation laws

as evidence that the President's program will operate efficiently and without injurious effect to either patients or physicians. On the whole, medical practice under these laws has been very satisfactory, but the number of people involved in comparison to the proposed system is small indeed. In the gigantic program the President proposes, there may be an attempt at voluntary participation and maintaining the relationships which exist under the workmen's compensation laws, but a heavy drain on the funds will soon bring The Man Behind the Desk into his own.

It is true, as President Truman says, that "Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people's needs." On the other hand, in such a vital thing as the health of the people, we had better go a little slow and be sure of our ground. We had better eliminate defects in sickness insurance medicine by experimenting with modest plans rather than jeopardize all medical service in this country.



**Service Physi-
cians Given
Runaround?**

Albert Deutsch, of leftist *PM*, never misses an opportunity to stir up controversy. In fact, this appears to be his forte. In fairness, your Observer must admit that he does a pretty good job of it. However, like most writers of his kind, he is not too exact in his reporting.

For example, in *PM* for November 6, there appeared an article, "Doctors Snafued in Army Get Runaround at Home," written by Mr. Deutsch. Among other things, Mr. Deutsch charges the American Medical Association with having "virtually forgotten" physicians who entered the armed forces.

"Thousands of Army doctors now returning to civilian life," Mr. Deutsch writes, "are bitterly resentful of the runaround they are getting from the Government and from their own medical societies in their efforts to reë-

establish themselves in their communities. They are almost as bitter as the many thousands who are still in uniform, uncertain as to when they'll get discharged, and feeling that their wasted skills may rust beyond repair before they get back.

"So angered are these men against what they consider a 'betrayal' by organized medicine that there is considerable talk about a possible revolt against the present ruling clique of the American Medical Association."

Mr. Deutsch is taking in a lot of territory when he implies that all medical societies are giving the returning service physicians the "runaround." For there are many societies, including the Medical Society of the District of Columbia, which are giving every assistance possible to service physicians.

It is true that there are a considerable number of medical officers, and your Observer knows a few of them, who are resentful at being kept in the armed forces when they have little or nothing to do. Some have been severely critical of the American Medical Association because they have felt more could have been done for the doctors in the services. Your Observer has commented on this criticism previously in this column. He is still not prepared to pass judgment on the Association's alleged failure to fulfill its obligations to service physicians. However, he is certain that the Association is fully capable of defending itself. But your Observer does know what has been done for our veterans in the Nation's Capital, and when Mr. Deutsch denounces all medical societies, he is being grossly unfair.

Among the complaints of service physicians, Mr. Deutsch says, are the following:

"It is now generally recognized that the military forces took out of civilian practice a great many more medical men than they actually needed. Organized medicine, through its own creature, the Procurement and Assignment Service, had a big role in sucking doctors into uniform voluntarily on the plea that the Army needed them. Once in, they were virtually forgotten by their medical societies."

"Many doctors past military age patriotically responded to the Army appeal for their service. Large numbers had families, and left practices built up ardu-

ously over a long period of years. When they entered service, their medical societies heaped words of praise upon them. They were assured that the A.M.A., the state and local medical societies were all establishing special veteran committees to safeguard their interests and prepare plans for easing their return to practice.

"Now, upon their return, they are finding that these committees, for the most part, existed only on paper. They find their practices taken over by doctors who had made money hand over fist during their absence. Many are unable to find office space to reopen practice. Many who had depended on promised priorities on surplus medical property for their equipment are getting a run-around instead. In these and other fields where the medical societies should have been protecting the veteran doctors, little or nothing has been done.

"The younger doctors who had gone directly into the Army from medical schools and hospital internships were looking forward to continuing their internships or residencies or taking up postgraduate work through the educational provisions of the GI Bill of Rights. Their frenzied applications for positions, in many instances, get no favorable response. The medical societies which promised to 'take care of them' have done nothing to facilitate their further training. Few medical schools or hospitals have reserved places for them. They have been left high and dry."

Not only has mischievous Mr. Deutsch taken in too much territory but he has deliberately drawn conclusions to suit his own ends. It is true that early in the war the Procurement and Assignment Service for Physicians of the War Manpower Commission was enthusiastically endeavoring to obtain every available doctor for the armed forces. It is easy enough at this point to look back and say that those in authority might have exercised better judgment. But the fact of the matter is that by and large the Service did a very creditable job. It made mistakes like all agencies of the Government, but they were not intentional nor deliberate. Furthermore, your Observer challenges Mr. Deutsch to prove that once in the service, physicians were forgotten by their medical societies. He is simply talking through his hat where most societies are concerned.

There is no doubt that doctors at home fared very well financially, and that many physicians who entered the armed services made great

sacrifices not only physically but financially. Except for a very few physicians who should have gone into the armed forces, civilian doctors had no choice but to stay where they were. They worked hard and naturally their incomes increased. But should they be condemned for circumstances beyond their control? One fact should not go unnoticed. Not a few of them have paid a heavy price physically for whatever financial prosperity they enjoyed.

As to priorities on surplus medical property, that is something that comes under Government control and supervision. It is reported that such supplies as physicians need are obtainable without too much difficulty.

With respect to the younger doctors who have gone directly into the armed forces from hospitals, they are receiving assistance. At least this is true in most urban centers where there are active medical organizations with full-time staffs.

It is perhaps to be expected that in these postwar years there is going to be much fault found with what was done during the war. And there will be justifiable criticism, too. It would be surprising if this were not so. But organized medicine should be given credit for the many worthwhile things it has done and is doing and should not be condemned without reservation.

Mr. Deutsch, like the rest of us, must make a living. As stirring up controversy seems to be his meal ticket, perhaps his charges should not be taken too seriously.



The Case for Fluorescent Lighting

In recent years clerical workers in more modern offices have become familiar with the fluorescent light which artificially simulates daylight. Some time ago your Observer obtained a fluorescent lamp for use on his desk. To him there was an unnatural quality about the light which he did not like and he discarded it. According to experts, his reaction was psychological and if he had continued its use he would

have found it much superior to the ordinary electric lamp.

Dr. James P. Luton makes some interesting observations on "Fluorescent Lighting and Its Effect Upon Visual Function" in the October number of the *Journal of the Oklahoma State Medical Association*. He has apparently made an exhaustive study of the technical aspects of fluorescent lighting as well as its effect upon the eyes. In describing the fluorescent lamp, he says it "consists of a cylindrical frosted glass tube of variable size and length, containing mercury vapor and lined with certain elements in powdered form. At each end of the tube there is an electrode with heating and starting unit for setting up and maintaining a flow of electrical current through the mercury vapor within the lamp. Action of this current upon the powdered chemical lining of the tube causes the particles of powder to fluoresce, thereby producing light throughout the entire length and inner circumference of the lamp. . . . The light produced is uniformly distributed over a relatively wide area in contrast to the conventional incandescent lamp, thus eliminating the intense focal brightness and concentrated heat of the latter type of lamp. The daylight fluorescent lamp produces light nearer natural daylight than any other artificial light so far produced."

There follows a description of the spectrum of the fluorescent lamp which, he says, may "be favorably compared to a combination of natural daylight and a mercury arc lamp."

How, then, does this light affect the eyes? "We do know," Dr. Luton writes, "that the eye evolved over a period of many, many years in daylight and sun-light which is many times brighter than any of the artificial lights thus far in use. We know also that the eye has remarkable powers of adapting itself to the extremes from bright sunlight to dark without apparent ill effect, so we may conclude that it certainly should be able to adapt itself to the spectrum and intensity of the fluorescent light at present in use."

"The lighting engineers are inclined to believe—and not without reason—that most, or all of the complaints laid at the door of this new type of lighting are due to poor engineering psychological reaction to any drastic change. . . . In other words they say that the fluorescent lamp should be properly shaded from view, just as any other type of lamp, that glare and reflection should be eliminated and that sufficient fixtures should be used at proper height to give about thirty-five (35) to fifty (50) foot candles of light evenly distributed throughout the area in which the light is being used.

"We can agree with the engineers that the psychological factor is important especially during times of stress such as we have had for the past four or five years. There is always a tendency on the part of some individuals to react unfavorably to any new circumstance and when large numbers are placed in new positions in a more or less regimented state, a few of the weaker ones will begin to complain. Their complaints, when referable to the eyes, may be due to one of any number of causes which they do not understand, and it is only natural for them to reach the conclusion that the new type of light is the underlying cause of their troubles. It is surprising how widespread the effect may be in the group as a whole, when one or two in that group begin registering some complaint."

"... I have not seen any signs of pathology or any reports of pathology in the eye, other than a mild conjunctivitis and, perhaps, a superficial keratitis which could be attributed to the use of the light in the usual form. There is a need for further investigation with regard to the effects of excess energy due to the mercury lines and for investigation of the infra-red and ultra-violet energy beyond the limits of the visible spectrum. I believe it is reasonable to consider the lamp safe for general use, and that it will be a valuable asset to the field of artificial lighting."

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Rest for the Aged

Rest for the aged has recently come in for some sharp criticism. Physicians have quite universally taken the position that rest is an effective method of retarding wear and tear on the human machine, especially in later years. But now it appears that rest, like many other things, is being overdone.

Writing in *Minnesota Medicine* for October, Dr. J. F. Norman devotes himself to the subject, "Abuse of Prolonged Rest in the Aged."

"The hospital and medical care of this large group with a high rate of invalidism," Dr. Norman says, "brings up a problem of increasing importance. At present a large number of patients in our general hospitals are sixty-five years of age and over. Some of them enter in terminal conditions and will never leave the hospital alive. Others who are not so ill run the risk of becoming confirmed invalids by too prolonged stay in bed, whether for medical or surgical care. Soon they lack the will to make an effort to get up and around; they become hopeless in outlook and, in time, mentally deficient. Without some incentive to get back soon to work or home these patients deteriorate very rapidly. All these older patients do not enter a hospital because of disease conditions peculiar to their age. A number of them will enter with conditions common to early life and old age, medical or surgical."

"With such aged patients entering our hospitals in increasing numbers it behooves the profession to reconsider the care of these people. There is a need for revision of our previous ideas of what constitutes proper care for all surgical and medical cases, and particularly, post-operative care. Respiratory and circulatory complications are rather too common during and following any bed rest. Many writers today stress the bad effects of prolonged bed rest. A review of such reports will disclose the fact that all are rather definitely in favor of shortening the period of bed rest. This is especially true in the case of older persons; the young seem to withstand such care better than the aged."

Dr. Norman's conclusions:

"Because of the many physical handicaps of these old-age patients no rule or procedure will be applicable to all cases and the physician will do well to be not too dogmatic in the handling of such cases. In a great majority of patients who are old and who need medical or surgical care, prolonged rest will be a definite hazard both from the point of view of their physical well-being and also because of the very marked psychic changes which may take place with the result that they may be greatly handicapped. While prolonged rest is an abused therapeutic procedure, too early rising or too little rest may be dangerous in some old patients. It would seem that the profession should strive to arrive at a correct balance between rest and activity in therapy."



"We Fear Those who peruse this column from month to month have These Reformers..." become familiar with your Observer's thesis that organized medicine must sponsor an adequate national health program without further delay if its voice

is to carry any weight with the public. If it had been as diligent in furthering such a program as it has been in opposing proposals which it does not favor, there would be little cause for criticism. But its position has been negative rather than positive. Your Observer has presented many variations of this theme, but this is the essence of what he has had to say.

Several examples of the negative approach might be given. At a recent meeting a representative of a medical society from a Southern state told of the employment of a public relations expert whose task it was to win public support for the society's stand against health legislation which it did not favor. There was little that was constructive in the program which he described. The society was simply "agin" everything. Your Observer, who was present, raised his voice in protest, stating that a negative position in these times would never do.

In the *Nebraska State Medical Journal* for November there appears an editorial entitled, "We Would Rather Be Free than Secure." The *Journal* is apparently disturbed by what it terms "liberal" elements in Congress.

"We fear," the *Journal* says, "these social reformers more than we do the psychotic rabble rousers. For while the rabble rouser receives encouragement and applause from a comparatively few narrowminded and frustrated individuals, the social reformer draws his support from large masses of honest and decent people who would like to see a better world. The danger, as we see it, lies in the method by which these 'liberals' are attempting to cure social ills. Liberty and freedom can neither be attained nor maintained without sacrifices on the part of the individual. The moment that centralized government assumes paternalistic supervision over its citizens, the citizen necessarily becomes a servant of the state. This condition is the keynote to totalitarianism which at first poses as a benevolent agent but in the end enslaves its subjects. It makes little difference whether such initial protective measures favor one class of the population or another; the end result is the same. As the state becomes strong the individual becomes correspondingly weak."

"The present efforts to bestow security upon able-bodied Americans are deeper than appears on the surface. The pending EMIC program and the Wagner-Murray-

Dingell Bill are only the prologue to the contemplated scheme for 'full protection.' We contend that the only protectors which can fully benefit our war veterans and our war workers are JOBS. The way to provide these jobs is through a sound industrial system. Americans like to earn a living and those who believe in insurance like to buy it when they choose and from whomever they choose. Let our 'liberals' get down to earth and stop flirting with false philosophies. Security cannot be achieved by compulsion. Even if it were possible it would not be worth the personal dignity and individual self-respect which would have to be sacrificed on the unholy altar of an entrenching bureaucracy. Americans would rather be free than secure."

Your Observer is not opposed to these views. In fact, he agrees with them. But where the health of the people is concerned we must do more than find holes in the proposals made by those with whom we disagree. Let us continue to oppose what we sincerely believe is not in the public interest, at the same time offering what we feel will benefit the people most. If anything will stop "reformers," it will be a positive rather than a negative program.



Veterans' Examinations

There seems to be some misunderstanding among members with respect to the arrangement entered into by the Society and the Veterans Administration under which veterans applying for pensions would be examined by volunteer physicians.

The Society's Committee on Industrial Medicine agreed to canvass members of the Society in the specialties specified by the Administration. These specialties were: otorhinolaryngology, ophthalmology, internal medicine, neurology, psychiatry, orthopedic surgery, and surgery. Names of those who volunteered to make examinations were to be forwarded to the Veterans Administration authorities, whereupon they they would be designated examining physicians and called upon to serve as needed. Physicians were to be compensated in accordance with an approved fee schedule. A clinic, it was decided, should be established at the Regional Office of

the Veterans Administration, 300 Indiana Avenue, N.W., where volunteer physicians would make examinations for two hours daily, Monday through Friday, from 12:00 to 2:00 p.m. The clinic was to be under the direction of Major Spencer V. Meade. Clerks, it was promised, would handle the paper work. It would be the physician's duty to submit professional findings in accordance with the procedures established by the Administration.

Prompt approval was given this plan by the Executive Board because of the emergency which existed. At the time this was written, some 85 physicians had responded to the request for volunteers. A number of physicians have called stating that they have not received a communication inviting them to participate. This was due either to oversight or to the fact that they were not in the specialties desired. Members who have not received a communication from the Committee and are in one of the above specialties should notify the Society's office promptly.

In view of a recent order issued by General Omar N. Bradley, Administrator of the Veterans Administration, eliminating certain physical examinations, comparatively few volunteers will be called upon at this time. However, the Society is informed that eventually the services of most of those who have volunteered will be needed.

The prompt and overwhelming response of our physicians is most gratifying, and proves again the desire of the medical profession to serve in every way possible.



Doctors Favor Diagnostic Clinics

The medical profession of Washington has shown considerable interest in diagnostic clinics. Taking cognizance of this interest the Executive Board of the Medical Society authorized the creation of a Subcommittee on Diagnostic Clinics to function under the direction of the Committee on Medical Care.

This Subcommittee already has accomplishments to its credit. It investigated rather thoroughly The Diagnostic Clinic at Johns Hopkins Hospital in Baltimore, reporting its findings to the Committee. Plans for a building to house a clinic were prepared by the United States Public Health Service at its request. Later representatives of the Subcommittee met with officials of George Washington and Georgetown Hospitals in an attempt to interest them in the establishment of diagnostic clinics for individuals of limited incomes in the new hospital buildings under construction. At least one of these institutions is definitely interested. The one thing the Subcommittee has not done is to poll physicians in the District to determine their views with respect to diagnostic clinics.

Recently a poll was undertaken by the Committee on Postgraduate Education of the Rhode Island Medical Society which had been delegated the task of studying diagnostic clinics and determining the support which such clinics would have if encouraged by the Society. A questionnaire which the Committee sent to members of the Society in April of this year elicited data of significance not only to the medical profession of Rhode Island but elsewhere.

Of some 600 active physicians in Rhode Island, 177 replied to the following questions:

"Approximately how many of your patients in the past year: (a) Voluntarily requested or sought study or treatment at an out-of-state clinic or hospital? (b) How many went to such clinics or hospitals at your suggestion?

"How do you look upon the establishment of one or more diagnostic centers for hospitalized patients in Rhode Island?

"If you favor such centers how do you think they could be most effectively established and operated?"

In answering the first question, 92 physicians reported that they had patients who had gone to out-of-state medical centers. Seventeen said that they had no knowledge of any of their

patients who attended out-of-state clinics. Surprisingly 75 of the 92 physicians reporting that their patients visited out-of-state clinics estimated that a total of 826 patients went to such clinics without being referred, 561 being referred. Commenting on these figures the Committee observed: "They certainly indicated a great exodus of patients to out-of-state clinics more often than not without their doctor's knowledge or consent. . . . It must represent a feeling on the part of physicians, and even more on the part of the public, that the best facilities, diagnostic and therapeutic, are not available in our state."

In answer to the second question, 102 were in favor of establishing diagnostic clinics, 24 were against, and 33 were doubtful. On the basis of these returns, the Committee states: "It is quite evident . . . that there is an overwhelming sentiment in favor of establishing one or more diagnostic centers."

The final question brought response from 120 doctors whose replies were favorable. However, very few offered suggestions as to the manner in which diagnostic centers should be established. Some thought that the centers should be operated by hospitals. Others proposed that they be controlled jointly by the hospital and medical society.

Your Observer believes if a canvass were made in Washington the result would be somewhat similar. There is no doubt that there are many patients here, too, who go elsewhere because facilities provided by diagnostic clinics are not available.

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"...Quite a Shindig..."

Readers of this column will recall that in the October issue of the MEDICAL ANNALS your Observer gave his impressions of a debate on the subject, "Should We Have Compulsory Federal Sickness Insurance?," which was broadcast by the American Forum of the Air last August. He said then, and he has not changed his mind since, that he did not think the exhibition was

beneficial to the people or the medical profession. While it undoubtedly was "a good show for some listeners," more heat than light had been thrown on a vitally important subject.

Early in October a similar debate was sponsored by the Jackson County Health Forum in Kansas City, Missouri. At that time the opponents were Congressman A. J. Biemiller, of Wisconsin, and Dr. Louis Bauer, member of the Board of Trustees of the American Medical Association. Dr. Morris Fishbein was the "interlocutor."

Dr. Vincent T. Williams, Editor of the *Jackson County Medical Society Weekly Bulletin*, provides his readers with some colorful impressions of the individuals participating and the worthwhileness of their discussion. He says of Mr. Biemiller, whom he describes as "forceful, personable," that he probably "figured a good offense was the best defense" and "wowed the audience with every histrionic emotion from A to B, he hit them with every device and implement except the kitchen stove. It went over with a bang." Dr. Bauer, he reports, presented the American Medical Association's case "in a scholarly manner; the reception was polite." Dr. Morris Fishbein, the "interlocutor," Dr. Williams observes, was "irrepressible and brilliant."

In evaluating the merits of the discussion, Dr. Williams writes:

"It is a curious thing how someone can say: 'You're not fit to sleep with a hog,' and it takes about ten times that much speechifying to talk the accused either in or out of this position. And even when the rebuttal is logical the impact of the charge still lingers on. This type of technic was much in evidence the other night. Also, intended or unintentional misstatements were not rare; many such went uncorrected.

"Very few who were there will sit down and study carefully either the text or the [Wagner-Murray-Dingell] Bill or the speeches made for and against it. They will carry away impressions and probably not one individual was changed in his opinion by the discussion.

"Even those who opposed the Wagner-Murray-Dingell Bill regretted that a stronger and a better case was not presented. To tell the truth, our side did not show up too

well. In contrast, the winsome Wisconsin salesman left a favorable impression even with those who disagreed.

"The ladies who arranged the party are to be congratulated on the size of the audience and the generally smooth performance given. It was good 'box-office.' As far as winning friends and influencing people, from the viewpoint of the medical profession, it was too bad that they were not serving tea!"

Dr. Williams' conclusion that it was "quite a shindig" just about tells the whole story. The medical profession should cut out such buffoonery and get down to serious business.



Most of us are continually being surprised by the unexpected behavior of people we know. Our impressions of them have become firmly rooted and we are not prepared for a deviation from their usual patterns of action, thought and speech.

Your Observer has attended national medical meetings for many years. He has therefore become familiar with the characteristics of prominent medical leaders. He knows something of their idiosyncrasies and, to some degree, their habits. He could state the views of many of them pretty accurately.

Among these medical leaders are several who he has come to feel will never be reconciled to change even when it is obvious that it is for the better. They are, in his opinion, reactionaries. They fight valiantly for the status quo, sometimes grudgingly giving ground. There are still a number of them in high places. He does not necessarily place Dr. Edward H. Cary, Past President of the American Medical Association, in this category. However, he has looked upon him as a conservative with slight liberal tendencies who believes the best interests of his profession lie in "holding the line." However, this estimate of Dr. Cary does not coincide with the views expressed by him in a guest editorial entitled, "Blue Cross Insurance and Medical Economics," appearing in the October number of *The Mississippi Doctor*.

"I have always been embarrassed to be on the negative side of any question," Dr. Cary writes. "I am much happier to be an advocate of something that seems right and progressive than to remain static or in opposition.

"There have been two or three bills introduced recently which have definite merit. The Hill-Burton bill which would make possible the development of hospitals where needed is in line with the thought I expressed as President of the Southern Medical Association in 1920. I expressed the thought that well trained doctors would not remain in small towns or in the country unless the city-county units provided the necessary service for them to do scientific work. Then there is another bill in Congress for providing funds for research and this is a comprehensive bill, which would make possible research in the basic sciences as well as support research in the medical schools of this country.

"I am advocating a comprehensive bill as a substitute for the Wagner-Murray-Dingell bill, not only taking care of these two important measures but also supplying grants in aid for the care of the under-privileged and the low income group through prepayment insurance programs, which need not require any kind of bureau or federal supervision."

Well! Well! Your Observer apparently doesn't know his medical leaders as well as he thought he did, or are some of them being "converted"?



Which Is the Weaker Sex? A remarkable decline in mortality among American wage earners is reported in the September number of the *Statistical Bulletin* published by the Metropolitan Life Insurance Company. According to the *Bulletin*, an analysis of many millions of Metropolitan Industrial policyholders reveals that "the age-adjusted death rate (ages 1 to 74 years) dropped 43 per cent among white females as against a decline of 26 per cent among white males between 1921-23 and 1941-43."

The *Bulletin* then draws some interesting comparisons.

"Surprisingly enough, the course of mortality for the chronic diseases of the heart, the leading cause of death, shows considerable difference for the two sexes. Although the trend of the death rate in each sex was upward

in the 1920's and down thereafter, the rise was much less marked and the subsequent decline much more pronounced among white females than among white males. The result has been that, whereas the mortality from this cause among the male policyholders is still somewhat higher than it was two decades ago, among the females the death rate has fallen by 17 per cent. At the same time, the excess male over female mortality has increased from 12 per cent to slightly more than 40 per cent. It should be noted, however, that the difference in mortality for the sexes was unusually small at the beginning of the period under review, because of the sharp drop in the death rate from heart disease among males during and immediately following the influenza pandemic of 1918-1919.

"For cancer, as for heart disease, the age-adjusted death rate among white males is higher than it was 20 years ago, while among females the mortality has declined over the period. . . .

"Contrasting trends are also evident in the mortality from ulcers of the stomach and duodenum. In the period under survey, the death rate from this cause was distinctly upward among white males but downward among white females. No satisfactory explanation seems to suggest itself as to the reasons for these divergent trends. Greater diagnostic precision has undoubtedly led to the recognition and reporting of an increasing number of cases, which fact may account, in part at least, for the recorded increase among males, but this makes the steady decrease in the mortality among women all the more puzzling. At present, deaths from peptic ulcers are very largely concentrated among men. . . ."

"For most of the more or less important causes of death, the mortality trends for the two sexes are not divergent, but parallel, with females usually recording a somewhat more rapid decline than males." For example, statistics reveal that tuberculosis has declined 64 per cent among the males in the past 20 years as compared to 94 per cent among females. In the same period there was an equal disparity between males and females where pneumonia was concerned. Other causes of death, the *Bulletin* says, where the trend was advantageous to females are influenza, appendicitis, homicides and accidents. "Deaths from violence which have always shown a preponderance among

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Washington Physicians of Yesterday



THOMAS ANTISELL, M.D., PH.D.

Few physicians today have heard of Dr. Thomas Antisell. However, a century ago he was one of Washington's most distinguished physicians.

Born in Dublin, Ireland, January 16, 1817, he was educated at Trinity College, studied medicine at the Dublin School of Medicine and the Irish Apothecary's Hall. He received his medical degree from the Royal College of Surgeons in 1839, thereafter pursuing his studies in Paris and Berlin. He practiced medicine in Dublin from 1845 to 1848. As one of the "Young Ireland Party," he was sentenced to exile and imprisonment but a friend procured him a position as surgeon on an outgoing vessel sailing for America.

Dr. Antisell arrived in New York City, November 22, 1848 and practiced medicine there until 1854, when he became geologist of the Pacific Railroad Survey. Later appointed Examiner in Chemistry of the U. S. Patent Office, he resigned in 1861 to enter the Union Army. He served with distinction as Brigade Surgeon, U. S. Volunteers; Medical Director, 12th Army Corps; Surgeon in Charge, Harewood Hospital, Washington, D. C.; and in other capacities. He was mustered out of service in October 1865, thereupon resuming his work in chemistry, becoming Chief Chemist in the U. S. Bureau of Agriculture. In 1871 he was invited by the Japanese Government to become technologist of a commission to develop the resources of the northern islands of Japan. Returning to the United States in 1876, he resumed his position in the U. S. Patent Office. He died June 14, 1893.

Dr. Antisell was Vice President of the Medical Society of the District of Columbia from 1865 to 1868, and in 1878. He received his Doctor of Philosophy degree from Georgetown University in 1881. A fine portrait of him now hangs in the offices of the Society.

PRESIDENT TRUMAN'S NATIONAL HEALTH PROGRAM

I. CONSTRUCTION OF HOSPITALS AND RELATED FACILITIES

The Federal Government should provide financial and other assistance for the construction of needed hospitals, health centers and other medical, health and rehabilitation facilities. With the help of Federal funds, it should be possible to meet deficiencies in hospital and health facilities so that modern services—for both prevention and cure—can be accessible to all the people. Federal financial aid should be available not only to build new facilities where needed, but also to enlarge or modernize those we now have.

In carrying out this program there should be a clear division of responsibilities between the States and the Federal Government. The States, localities and the Federal Government should share in the financial responsibilities. The Federal Government should not construct or operate these hospitals. It should, however, lay down minimum national standards for construction and operation, and should make sure that Federal funds are allocated to those areas and projects where Federal aid is needed most. In approving State plans and individual projects, and in fixing the national standards, the Federal agency should have the help of a strictly advisory body that includes both public and professional members.

Adequate emphasis should be given to facilities that are particularly useful for prevention of diseases—mental as well as physical—and to the coördination of various kinds of facilities. It should be possible to go a long way toward knitting together facilities for prevention with facilities for cure, the large hospitals of medical centers with the smaller institutions of surrounding areas, the facilities for the civilian population with the facilities for veterans.

The general policy of Federal-State partnership which has done so much to provide the magnificent highways of the United States can be adapted to the construction of hospitals in the communities which need them.

II. EXPANSION OF PUBLIC HEALTH, MATERNAL AND CHILD HEALTH SERVICES

Our programs for public health and related services should be enlarged and strengthened. The present Federal-State coöperative health programs deal with general public health work, tuberculosis and venereal disease control, maternal and child health services and services for crippled children.

These programs were especially developed in the ten years before the war and have been extended in some areas during the war. They have already made important contributions to national health, but they have not

yet reached a large proportion of our rural areas, and, in many cities, they are only partially developed.

No area in the Nation should continue to be without the services of a full-time health officer and other essential personnel. No area should be without essential public health services or sanitation facilities. No area should be without community health services such as maternal and child health care.

Hospitals, clinics and health centers must be built to meet the needs of the total population, and must make adequate provision for the safe birth of every baby, and for the health protection of infants and children.

Present laws relating to general public health, and to maternal and child health, have built a solid foundation of Federal coöperation with the States in administering community health services. The emergency maternity and infant care program for the wives and infants of service men—a great wartime service authorized by the Congress—has materially increased the experience of every State health agency, and has provided much-needed care. So too have other wartime programs such as venereal disease control, industrial hygiene, malaria control, tuberculosis control and other services offered in war essential communities.

The Federal Government should coöperate by more generous grants to the States than are provided under present laws for public health services and for maternal and child health care.

The program should continue to be partly financed by the States themselves, and should be administered by the States. Federal grants should be in proportion to State and local expenditures, and should also vary in accordance with the financial ability of the respective States.

The health of American children, like their education, should be recognized as a definite public responsibility.

In the conquest of many diseases, prevention is even more important than cure. A well-rounded national health program should, therefore, include systematic and widespread health and physical education and examinations, beginning with the youngest children and extending into community organizations. Medical and dental examinations of school children are now inadequate. A preventive health program, to be successful, must discover defects as early as possible. We should, therefore, see to it that our health programs are pushed most vigorously with the youngest section of the population.

Of course, Federal aid for community health services—for general public health and for mothers and children—should complement and not duplicate prepaid medical services for individuals, proposed by the fourth recommendation of this message.

III. MEDICAL EDUCATION AND RESEARCH

The Federal Government should undertake a broad program to strengthen professional education in medical and related fields, and to encourage and support medical research.

Professional education should be strengthened where necessary through Federal grants-in-aid to public and to non-profit private institutions. Medical research, also, should be encouraged and supported in the Federal agencies and by grants-in-aid to public and non-profit private agencies.

In my message to the Congress of September 6, 1945, I made various recommendations for a general Federal research program. Medical research—dealing with the broad fields of physical and mental illnesses—should be made effective in part through that general program and in part through specific provisions within the scope of a national health program.

Federal aid to promote and support research in medicine, public health and allied fields is an essential part of a general research program to be administered by a central Federal research agency. Federal aid for medical research and education is also an essential part of any national health program, if it is to meet its responsibilities for high grade medical services and for continuing progress. Coördination of the two programs is obviously necessary to assure efficient use of Federal funds. Legislation covering medical research in a national health program should provide for such coördination.

IV. PREPAYMENT OF MEDICAL COSTS

Everyone should have ready access to all necessary medical, hospital and related services.

I recommend solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system. This is not socialized medicine.

Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk, and to benefit the insured who actually suffers the loss. If instead of the costs of sickness being paid only by those who get sick, all the people—sick and well—were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately served without overburdening anyone. That is the principle upon which all forms of insurance are based.

During the past fifteen years, hospital insurance plans have taught many Americans this magic of averages. Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people's needs. Only about 3 per cent or 4 per cent of our population now have insurance providing comprehensive medical care.

A system of required prepayment would not only spread the costs of medical care, it would also prevent much serious disease. Since medical bills would be paid by the insurance fund, doctors would more often be consulted when the first signs of disease occur instead of when the disease has become serious. Modern hospital, specialist and laboratory services, as needed, would also become available to all, and would improve the quality and adequacy of care. Prepayment of medical care would go a long way toward furnishing insurance against disease itself, as well as against medical bills.

Such a system of prepayment should cover medical, hospital, nursing and laboratory services. It should also cover dental care—as fully and for as many of the population as the available professional personnel and the financial resources of the system permit.

The ability of our people to pay for adequate medical care will be increased if, while they are well, they pay regularly into a common health fund, instead of paying sporadically and unevenly when they are sick. This health fund should be built up nationally, in order to establish the broadest and most stable basis for spreading the costs of illness, and to assure adequate financial support for doctors and hospitals everywhere. If we were to rely on State-by-State action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross State boundary lines.

Medical services are personal. Therefore the nationwide system must be highly decentralized in administration. The local administrative unit must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions. Locally as well as nationally, policy and administration should be guided by advisory committees in which the public and the medical professions are represented.

Subject to national standards, methods and rates of paying doctors and hospitals should be adjusted locally. All such rates for doctors should be adequate, and should be appropriately adjusted upward for those who are qualified specialists.

People should remain free to choose their own physicians and hospitals. The removal of financial barriers between patient and doctor would enlarge the present freedom of choice. The legal requirement on the population to contribute involves no compulsion over the doctor's freedom to decide what services his patient needs. People will remain free to obtain and pay for medical service outside of the health insurance system if they desire, even though they are members of the system; just as they are free to send their children to private instead of to public schools, although they must pay taxes for public schools.

Likewise physicians should remain free to accept or reject patients. They must be allowed to decide for themselves whether they wish to participate in the health insurance system full time, part time, or not at all. A physician may have some patients who are in the system and some who are not. Physicians must be permitted to be represented through organizations of their own choosing, and to decide whether to carry on in individual practice or to join with other doctors in group practice in hospitals or in clinics.

Our voluntary hospitals and our city, county and State general hospitals, in the same way, must be free to participate in the system to whatever extent they wish. In any case they must continue to retain their administrative independence.

Voluntary organizations which provide health services that meet reasonable standards of quality should be entitled to furnish services under the insurance system and to be reimbursed for them. Voluntary coöperative organizations concerned with paying doctors, hospitals or others for health services, but not providing services directly, should be entitled to participate if they can contribute to the efficiency and economy of the system.

None of this is really new. The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have misnamed it "socialized medicine."

I repeat—what I am recommending is not socialized medicine. Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed.

Under the plan I suggest, our people would continue to get medical and hospital services just as they do now—on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all-important difference: whether or not patients get the services they need would not depend on how much they can afford to pay at the time.

I am in favor of the broadest possible coverage for this insurance system. I believe that all persons who work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employees, Government employees and employees of non-profit institutions and their families.

In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies. Increased Federal funds should also be made available by the Congress under the public assistance programs to reimburse the States for part of such premiums, as well as for direct expenditures made by the

States in paying for medical services provided by doctors, hospitals and other agencies to needy persons.

Premiums for present social insurance benefits are calculated on the first \$3,000 of earnings in a year. It might be well to have all such premiums, including those for health, calculated on a somewhat higher amount, such as \$3,600.

A broad program of prepayment for medical care would need total amounts approximately equal to 4 per cent of such earnings. The people of the United States have been spending, on the average, nearly this percentage of their incomes for sickness care. How much of the total fund should come from the insurance premiums and how much from general revenues is a matter for the Congress to decide.

The plan which I have suggested would be sufficient to pay most doctors more than the best they have received in peacetime years. The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists and nurses for the services they render.

Federal aid in the construction of hospitals will be futile unless there is current purchasing power so that people can use these hospitals. Doctors cannot be drawn to sections which need them without some assurance that they can make a living. Only a nation-wide spreading of sickness costs can supply such sections with sure and sufficient purchasing power to maintain enough physicians and hospitals. We are a rich nation and can afford many things. But ill health which can be prevented or cured is one thing we cannot afford.

V. PROTECTION AGAINST LOSS OF WAGES FROM SICKNESS AND DISABILITY

What I have discussed heretofore has been a program for improving and spreading the health services and facilities of the Nation, and providing an efficient and less burdensome system of paying for them.

But no matter what we do, sickness will of course come to many. Sickness brings with it loss of wages.

Therefore, as a fifth element of a comprehensive health program, the workers of the Nation and their families should be protected against loss of earnings because of illness. A comprehensive health program must include the payment of benefits to replace at least part of the earnings that are lost during the period of sickness and long-term disability. This protection can be readily and conveniently provided through expansion of our present social insurance system, with appropriate adjustment of premiums.

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Military Affairs

ALL BUT 11,000 DOCTORS TO BE RELEASED BY NEXT JUNE

Army doctors are being released faster than the Army is reducing its total strength, in spite of the large number of battle casualties still remaining in hospitals and the requirement of doctors for separation center work, according to Major General Norman T. Kirk, Surgeon General of the Army, who spoke recently in New York in appreciation of the services rendered by member hospitals of the United Hospital Fund of New York.

"The peculiar situation that we find ourselves in is that demobilization, in which everyone is concerned, cannot proceed without the help of thousands of doctors—2,000 of whom are devoting their medical services solely to separation centers," General Kirk said. "By the first of January more than 14,000 doctors will have been returned to

civilian life, which is more than one third of the total number of doctors comprising the Army Medical Corps at its peak. By June of next year we anticipate releasing all but 11,000 doctors."

General Kirk, stating the peak hospital load in the United States to be 318,000, pointed out that there is still a need for medical personnel and that "one of our greatest problems is to hold enough doctors in the service to give the maximum medical care to our patients."

"I want to assure you," General Kirk concluded, "that, first, the Army Medical Department is going to continue to give to the sick and wounded soldiers of this war the best medical care known to science, and secondly, that it is going to return to civilian life as rapidly as possible every Medical Department officer whose services are not essential to the Army."

MORE ABOUT POSTGRADUATE COURSES AT G.W.U.

In previous issues of the ANNALS, the program of postgraduate instruction at the George Washington University School of Medicine has been presented in outline form. Schedules of courses are shown in an advertisement on page ix in this issue of the ANNALS.

It is now possible to fill in some of the details in the various courses. Fully detailed printed programs are being prepared.

The list of distinguished guest physicians who will participate includes the following:

Dr. Charles C. Wolferth, Professor of Clinical Medicine, University of Pennsylvania, will preside at a Roundtable Conference on "Management of Congestive Heart Failure" on February 11, 1946, and will also present "Common Diseases of the Chest and Abdomen Simulating Heart Disease."

Dr. Alvan L. Barach, Associate Professor of Medicine, Columbia University College of Physicians and Surgeons, will discuss "Modern Therapy of Bronchial Asthma" and will present his work on "Positive Pressure and Aerosols" in a

symposium on "Recent Advances in the Treatment of Chronic Suppurative Diseases of the Lung and Pleura," at which he presides on February 13.

Dr. H. L. Bockus, Professor of Gastroenterology, University of Pennsylvania, will present the "Medical Management of the Uncomplicated Peptic Ulcer" on February 15 and will discuss "Obstruction and Hemorrhage" in a Roundtable Conference on Peptic Ulcer.

Dr. Arthur Grollman, Professor of Medicine and Head of the Department of Experimental Medicine at Southwestern Medical College, Dallas, Texas, will discuss his work on "Recognition and Management of Diseases of the Adrenals" on February 18 and will participate in a symposium on "Diseases of the Thyroid" on the same day.

Dr. Nolan D. C. Lewis, Professor of Psychiatry of Columbia University College of Physicians and Surgeons, will present cases of "Schizophrenia and Allied Conditions" on February 28 in the course in Psychiatry and Neurology.

Dr. Frederick H. Allen, Director of the Philadelphia Child Guidance Clinic, will discuss the management of behavior problems in children on March 1.

Dr. J. Earle Moore, Associate Professor of Medicine, Johns Hopkins University, will discuss the "Diagnosis and

Treatment of Early Syphilis" on March 16 in the course in Infectious Diseases.

Dr. Samuel Allison Cosgrove, Clinical Professor of Obstetrics, Columbia University College of Physicians and Surgeons, will discuss "X-Ray Diagnosis in Pregnancy" and present "Indications for Cesarean Section" in the program in Obstetrics on March 21.

Dr. Louis Clerf, Professor of Laryngology and Bronchscopy at Jefferson Medical College, will participate on April 4 in the program presented by the Department of Otorhinolaryngology.

Dr. Lloyd H. Mousel, Consultant in Anesthesia to the Surgeon General, U. S. Army, formerly of the Mayo Clinic, will discuss "The Anesthetic Management of Shock" on April 9 in the program on Anesthesiology.

As the plans for the formal postgraduate course

are being completed, many inquiries are also being received about the preceptorships available in the specialties. Because of the great interest shown in this phase of the program offered by the School of Medicine, the inquiry is being expanded into several additional states so that positions can be made available to a greater number of men.

It is hoped that a plan can be worked out whereby physicians practicing in the metropolitan area of Washington can attend certain of the postgraduate courses on a part-time basis.

Inquiries about the program should be addressed to the Director of Postgraduate Instruction, George Washington University School of Medicine, 1335 H Street, N. W., Washington 5, D. C.

GENERAL KIRK RECEIVES DISTINGUISHED SERVICE MEDAL

Major General Norman T. Kirk, Surgeon General of the Army, has been awarded the Distinguished Service Medal by General Brehon Somervell, Commanding General of the Army Service Forces, in recognition of his "outstanding leadership... in directing the largest Medical Department in the history of the United States Army."

General Kirk's career with the Army Medical Department began in 1912 when he entered the Army as a First Lieutenant. He served as Chief of Surgical Service at Sternberg General Hospital, in Manila; Letterman General Hospital, San Francisco; and Walter Reed General Hospital, Washington, D. C. In 1914 he was with a field hospital in Vera Cruz, New Mexico. In 1942, then a Colonel, he was assigned as Commanding Officer of Percy Jones General Hospital, and in 1943 was promoted to Brigadier General. Later in the same year he was appointed Surgeon General, with the rank of Major General.

Born in Rising Sun, Maryland, General Kirk is a graduate of the University of Maryland Medical School, and has written books on medical subjects, which are used as textbooks, and is a member of the following medical associations: American Medical Association; American Surgical Association; American Orthopaedic Association; American Academy of Orthopaedic Surgeons; U. S. A. Typhus Com-

mission; Central Committee, American Red Cross; Board of Commissioners, U. S. Soldiers Home; Association of Military Surgeons; Federal Board of Hospitalization; National Research Council; National Board of Medical Examiners; Board of Directors, American Foundation for Tropical Medicine; and Pan American Medical Association.

The official citation said, "By careful planning, efficient administration, and dynamic example, he (General Kirk) made possible extraordinary care for sick and wounded American soldiers—care which has never been equalled in any war. He supervised the selection of qualified medical specialists who were assigned to posts stretching from the forward areas to general hospitals in the Zone of the Interior, and combined their exceptional talents with a prompt evacuation system to achieve unprecedented results. Under his able guidance every effort was made to utilize the newer methods of medical and surgical treatment and to develop new technics. His plans for the care of battle casualties and outstanding efforts to prevent disease among the troops resulted in an enormous reduction in mortality and morbidity. Bearing tremendous responsibilities, General Kirk accomplished his trying task in a distinctly superior manner, thereby making a major contribution to the success of American arms."

MAJOR GENERAL LULL GIVEN AWARD

Major General George F. Lull, Deputy Surgeon General of the Army, has been awarded the Distinguished Service Medal for "exceptionally meritorious conduct in the performance of outstanding services in the Office of The Surgeon General from June 1940 to August 1945."

First commissioned into the Army Medical Reserve as a First Lieutenant in 1912, General Lull had reached the rank of temporary Lt. Colonel by 1918, though he later reverted to the rank of Major until the confirmation of his rank as Lt. Colonel in 1933. In 1939 he was promoted to Colonel, in 1943 to Brigadier General, and in 1943 to his present rank. He served in France with the AEF as Commanding Officer of Base Hospital No. 35, and, previous to World War I, in the Canal Zone at Camp Gaillard. He has served in various positions at Walter Reed General Hospital, including Chief of Laboratory Service, Director of Laboratories and Professor of Bacteriology, Director of the Occupational Therapy Department, and Instructor at the Army Medical School. In addition to these

duties, he has served as Assistant to the Eighth Corps Area Surgeon, Medical Advisor of the Governor General of the Philippines, and as Director of Military Personnel and Chief of the Statistical Division in the Office of The Surgeon General.

The citation: "In his capacity as Chief of the Personnel Service he was responsible for developing plans to augment the various officers' corps and the enlisted and civilian personnel of the Medical Department during the Nation's first total mobilization of medical manpower. As Deputy Surgeon General, he was largely responsible for establishing policies and directing studies which resulted in many outstanding medical achievements such as the advancement in preventive health measures, the remarkably low incidence of disease, and the low mortality from both disease and battle wounds. General Lull's skillful discharge of difficult duties and his devotion to the mission of the Medical Department contributed in important degree to the success of the Army's unprecedented medical program."

LETTERS FROM MEMBERS IN THE SERVICES

From Lt. Colonel William A. Ryon, c/o Postmaster, New York, N. Y.:

My dear Mr. Wiprud: It has been some time since I wrote you last during which I have moved over considerable of the earth's surface. My last letter was from France. Since then, my unit has moved half way around the world to the Philippines.

Yes, we were one of the unlucky outfits to be shipped from the European area to the Pacific. It was a pretty rugged trip, spending thirty-five hot days on the water, packed in as tight as humanly possible.

Since arriving in the Philippines two months ago, we have been lying around doing nothing. We are supposed to be going to Japan; but as yet, there is no sign of transportation to carry us. Morale is pretty low with us, particularly amongst the medical and dental officers. Our officers have not seen any professional work now for over six months. This is true for many other medical units. There are thousands of medical officers who have done little or nothing in the way of medical work for the past year. Little or nothing is being done to get us out of this surplus class, and back where we can pursue the work we are trained for. It is pretty discouraging but all we can do is hope.

I was glad to read in your last letter that my friend Clayton Hixson was back home. Clayton did a fine job in England

and France, and richly deserves to be out. I had the pleasure of serving as his executive officer for several months in France, and enjoyed our service together very much indeed.

Your letters continue to be a great help to us still in the service. There are many like myself who have been in for going on four years, or more, and feel that we have given our bit now that hostilities are over. Now, more than ever, we want to know what is going on back home. We all wonder about the future and anxiously await our chance to get back to our chosen work.

Give my regards to the Society. Here's hoping that we can all show up for a complete roll call before many more months have passed.

From Lt. Comdr. Aloysius J. B. Connolly, U. S. Naval Air Station, Patuxent River, Md.:

Dear Ted: I have been back from Newfoundland since midsummer but have been tardy about notifying you of my change of address.

I am at present at the Naval Air Test Center, Patuxent River, Md. and would like to have future bulletins and communications sent to me here.

I hope to be able to call on you in town soon. [EDITOR: He did and we had a good visit.]

From Lt. Comdr. J. Keith Cromer, c/o Fleet Post Office, San Francisco, Calif.:

Dear Mr. Wiprud: After many months of waiting one of your news letters finally came through and was I glad to get it.

I have had good intentions of writing to you for a long time but somehow never got around to it. So at this time I will tell you a little bit about my travels and also enclose a copy of our ship's paper which may be of some interest to you. You will note that the paper is devoted almost exclusively to information about the typhoon which our ship managed, by the grace of God, to survive. This was the most exciting thing that has happened to us in all our travels, and an experience that none of us wish to repeat.

In brief I can say that I have been from San Francisco to Shanghai with stops at several of the islands in between. At times we have been fairly busy with a fair amount of surgery, which of course breaks the monotony of endless days at sea.

Now that the fighting is actually over, it goes without saying that we are all anxious to return home and pick up the threads of our prewar existence. It also goes without saying that we hope the folks back home haven't forgotten those of us who are still out here trying to get things "squared away" so that we can return home.

From Lt. Comdr. Ralph Crowley, Chelsea, Mass.:

Dear Mr. Wiprud: I enjoy your letters and the *Medical Annals*. Particularly interesting and impressive are the *Annals'* editorial and news columns. This is because they present various sides of debatable issues, such as government organized medicine. Congratulations on your liberality and insistence on democratic procedure in your columns.

To my mind a difficulty with "socialized medicine" is that, when and if enacted, people will expect it not to do a job as well as it can, but something much more. People will expect that all of their demands for treatment and cure will be met without delay, whether or not they have a treatable condition. No system and no doctor can do this. Yet no one I know has sufficiently emphasized this. Nor has anyone stressed the fact that 50 per cent of complaints have no physical basis and cannot be relieved by medicine or surgery. As far as I know, psychiatric treatment is not contemplated by the bills before Congress. Someone should figure out and tell Congress and the people just what per cent of complaints and ailments "socialized medicine" will be able to treat. As a guess, I would say about 25 per cent.

Actually socialized medicine will do a great deal less to satisfy people's demands on it than do private practitioners the demands on them. This however may be a good, although unsatisfying, result.

From Lt. Colonel Edward J. Grass, c/o Postmaster, San Francisco, Calif.:

Dear Ted: This will be the last letter I am writing you as received news we would be getting on the homeward-bound boat around 1st of October. Something I have been looking forward to for a long time after being in the Pacific 42 months. Do you think I will get the curvature of the spine when I sleep in a bed with a mattress? Hope to be dropping in on you before not too long.

Dear Ted: Just a few words to let you know I've been thinking about you. The ships assigned to take the 37th Division to the States arrived in port today, so I will be on my way any day now. I just wrote my wife and told her she had better begin staying home at night. I will be getting to my family at Grand Rapids, Michigan, just about Christmas time, and take the opportunity now to wish you a very fine Christmas, and maybe I am the first to have the pleasure of doing so.

From Lt. Comdr. Zigmond M. Lebensohn, c/o Fleet Post Office, San Francisco, Calif.:

Dear Mr. Wiprud: We are now cruising placidly through waters which only a few weeks ago were heavily infested with Jap subs and ships. From where I am writing I can see the coastline of Honshu and Fujiyama towering in the distance. We should reach our anchorage by evening but in the meantime we are proceeding very cautiously because of the many stray floating mines. We have already had to dodge two, and we are travelling under "Condition Zebra"—all watertight compartments closed. A few fishing sampans off shore are now visible—the only signs of Japanese naval activity. For my money I should like to keep it so.

For the last few months I have been chief psychiatrist on board this excellent naval hospital ship. I shall have charge of all the psychiatric cases among the recently released American prisoners who were so badly treated in the Jap prison camps. We have an unusually fine physical setup with all the latest facilities and we plan to give these men the very finest care we know. They surely deserve it.

I have been enjoying this duty immensely and would not have missed it for the world. (We have just had one of our navy planes fly overhead and circle about to welcome us to Japan!) Please give my very best to all my friends and colleagues. I'll be back in the fold as soon as we get this job done.

From Major Ernest Michaelson, Walter Reed Hospital, Washington, D. C.:

Dear Ted: It seems that every time I write to you I am changing my address, but at least this time it will be much closer to you. At present I am at the Walter Reed Hospital and expect to be separated from the service by the first of the year. While here I have met several doctors whom I knew before entering the service, as Dr. Allen Cross. I have now been in the service five years and upon getting out hope to get an assistantship or residency in obstetrics—gynecology.

From Major William J. Tobin, Cushing General Hospital, Framingham, Mass.:

Dear Mr. Wiprud: Several months ago I stopped by to see you but you were on your well earned vacation. At that time I was "heading for the blue Pacific." I got as far as the West Coast and my orders were revoked and I returned to New England. While the transcontinental trip was "long it was short." I was in the State of Washington long enough to get some beautiful colored pictures of snow-capped Mt. Rainier and also catch a nice salmon trout in Puget Sound.

Now it seems that I will soon resume that long cherished and wished for status of civilian—I wonder how that old term of “Doctor” will sound. (I believe great.) Even “Doc” will sound good. The other day a young G. I. said, in speaking to me, “Doctor”—then—“I’m sorry, Sir, I meant Major.” Forgive him, you know I did.

I am anxiously looking forward to returning to Washington. Only hope the housing situation isn’t as bad as it is reported up here in New England.

I promise to stop around and “talk these past years over” with you when I do return.

Expect to be out in the very near future.

From Captain James M. Loftus, c/o Postmaster, San Francisco, Calif.:

Dear Mr. Wiprud: A few lines to say hello. I am now in Japan and have been stationed in the Tokyo-Yokohama area for two months. Both of these cities received considerable damage from bombs and while travelling around one can understand why the Japs surrendered. The Japs are very docile and coöperative although at first they acted very suspicious to us.

Our hospital is located in a former Jap Air Force hospital. Our main causes of sickness are respiratory diseases and malaria.

My old outfit, The Americal Division, is leaving for home this month but I do not have enough points to accompany them. Home surely would look good after 25 months overseas. I hope I will have the pleasure of seeing you real soon at the Medical Society.

From Lieutenant Jack L. Derzavis, c/o Fleet Post Office, San Francisco, Calif.:

Dear Ted: Since I last communicated with you, I have left Miami and have accomplished a bit of travelling about the Pacific. I received orders in May to relieve another dermatologist at Nouméa and after a rush job through Washington to deposit my family I flew to the West Coast only to delay there five weeks awaiting transportation. We made a rather circuitous route and I have spent time in Pearl Harbor and Guadalcanal. Finally we arrived at Espiritu Santo, New Hebrides and I received dispatch orders to remain here rather than proceed to Nouméa.

I am rather pleased with my present duty and I find the environment not half bad. We have eight doctors here now with sufficient work for two but the base is folding as rapidly as transportation will allow. Needless to add that we feel our time completely wasted and the entire area to be useless. And we are rather peeved at the discriminatory point system in the Navy which practically requires one to be aged and of impossibly long service to get discharged. It is rather discouraging to learn that after 40 months of service my accrued 47 points under the present system leaves another 17 months out here or 24 in the States required to amass a total of 60. We hope that there will soon be a drastic reduction in the critical score to there more within reason.

In addition we receive no information concerning A. M. A. and other medical organization activities within the relationship of the discharge of physicians and the present plan for

CALENDAR OF MEETINGS

November 2	Classification Committee
November 8	Section on Neurology and Psychiatry
November 14	Scientific Meeting of Society
November 15	Committee on Public Health Section on Pediatrics
November 16	Committee on Public Policy
November 19	Medical Bureau Committee
November 26	Executive Board
November 27	Board of Censors
November 28	Scientific Meeting of Society
November 29	Subcommittee on Group Practice

demobilization. A. A. P. A. has sent me a little literature denoting their activity and they appear to be the only organization that is willing to get in there and pitch.

I would appreciate receiving your grand letter, and any other information you consider pertinent to the above subject. I shall be anticipating their arrival in the very near future.

I want to take this opportunity to let you know that we were very pleased by the alacrity with which Group Hospitalization handled our recent confinement bill at the St. Francis Hospital at Miami Beach, Florida. I shall certainly commend the organization highly in the future.

I hope you do not mind being burdened by these important problems. Others must mirror my sentiments. It surely will be a great day when I become a free agent and private practitioner again.

MEETINGS

Wednesday, January 16

“Some of the Newer Developments in Thyroid Disease Including Thiouracil and Thiobarbital,” FRANK H. LAHEY, M.D., F.A.C.S., Director, Lahey Clinic, Boston.

Wednesday, January 23

MAJOR GENERAL PAUL R. HAWLEY, Acting Surgeon General of Veterans Administration, will address the Society. Subject will be announced.

Wednesday, January 30

The Washington Heart Association will sponsor the program. DANIEL C. ELKIN, M.D., F.A.C.S., Professor of Surgery, Emory University School of Medicine, Atlanta, Ga., will give an address on a subject to be announced.

News and Personals

The American Association for the Study of Goiter again offers the **Van Meter Prize Award** of \$300 for the best essay submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in Chicago in April or May 1946, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations, not to exceed 3,000 words in length. A typewritten, double-spaced copy should be sent to the corresponding Secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia, not later than February 20, 1946.

The **Mississippi Valley Medical Society** is resuming its annual Essay Contest which has not been held during the war. In 1946 it offers a cash prize of \$100, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics) and practical value to the general practitioner of medicine. Contestants must be members of the American Medical Association who are residents of the United States. Contributions shall not exceed 5,000 words, be submitted in five copies, typewritten, and must be received not later than May 1, 1946. Further details may be secured from Dr. Harold Swanberg, Mississippi Valley Medical Society, 209 W. C. U. Building, Quincy, Ill.

The first **Tri-City Meeting of the Sections on Neurology and Psychiatry** was held in Baltimore, December 6, at the Emerson Hotel. The following papers were presented by Baltimore physicians: "Comparative Studies on Double Sensory Systems in the Cerebral Cortex," Dr. Clinton N. Woolsey; "Experiences with Intracranial Arterial Aneurysms," Dr. Francis J. Otenasek; "Combat Fatigue," Dr. John C. Whitehorn.

Veteran medical officers who are separated from service may apply for purchase of surplus war mate-

rials at Room 254, 101 Indiana Avenue, N. W., telephone Republic 7500, Extension 2756. It is necessary to apply in person as proof of separation from the service is required.

Civilian physicians are not eligible to apply. If interested, however, the small war plants Corporation is willing to try a test case to see if physicians may be classified as "small business."

The **Clinico-Pathological Society** held a dinner meeting, December 4 at the Chevy Chase Club. Dr. Henry C. Macatee was host. Papers read before the group were as follows: "Cancer of the Prostate," Dr. William P. Herbst; "Pulmonary Embolism," Dr. A. C. Christie; "Chest Tumors and Routine Examinations," Dr. Janvier W. Lindsay.

Dr. Henry Darner was host to the Society, November 6, at the Kennedy-Warren Apartments. Papers presented during the evening were as follows: "Carcinoma of the Prostate," Dr. William P. Herbst; "Two Cases of Splenomegaly with Splenectomy," Dr. Arch L. Riddick; "Exclusion Operation for Duodenal Ulcer," Dr. William B. Marbury.

The following officers are serving this year:

Dr. Henry L. Darner, *President*; Dr. James N. Greear, Jr., *Secretary-Treasurer*.

At the meeting of the **Section on Neurology and Psychiatry**, November 8, Dr. Roger S. Cohen related "Some Observations Based on Four and One-half Years in the Naval Medical Corps." Dr. Vasilios S. Lambros read a paper on "Clinical Evaluation of Electroencephalography in Brain Tumors and Convulsive States."

The 42nd Annual Meeting of the **Graduate Nurses' Association and the League of Nursing Education of the District of Columbia** convened November 12 and 13 in the Medical Society's building.

The first meeting of the **Metropolitan Washington Tuberculosis Conference** was held at the Glenn

Dale Sanatorium, October 25. Dr. Herman Hilleboe, guest speaker at the morning session, chose for his subject, "Tuberculosis Control in Postwar Period in the Metropolitan Area." His paper was discussed by the state health officers from Maryland, Virginia and the District of Columbia. The afternoon session was devoted to round table discussions. Dr. Daniel L. Finucane, Chairman of the Medical Round Table, presented as the topic for discussion, "The Management of Patient with an Early Tuberculous Infiltration."

Dr. Joseph S. Wall and Dr. Wallace Mason Yater were given a testimonial banquet at Hotel Twenty-four Hundred by the Senior Class of Georgetown University School of Medicine on November 19. The occasion of the banquet was the resignation of Dr. Wall and Dr. Yater from the faculty of Georgetown University School of Medicine and in recognition of their services as teachers. Members of the Departments of Medicine and Pediatrics were present. Black and white portraits of Dr. Wall and Dr. Yater were presented to them and autographed by all those present. The portraits were done by one of the students, Mr. Charles Waite.

Mr. George Schreiner was toastmaster and the President of the Senior Class, Mr. Samuel Shea, spoke for the class.

Several local ophthalmologists assisted the **District of Columbia Society for the Prevention of Blindness** in observing Sight Saving Week, November 26 through December 2. During a series of radio talks, Dr. Inez E. Wilber spoke on "Care of Infants' Eyes"; Dr. C. R. Naples, "Sight Conservation among Children"; and Dr. Benjamin Rones, "The Medical and Social Aspects of Glaucoma."

The Women's Medical Society of the District of Columbia has elected the following officers for 1945-46:

Dr. Ella Enlows, *President*; Dr. Grace G. Purse, *Vice President*; Dr. Paula R. Kaiser, *Recording Secretary*; Dr. Cecile L. Fusfeld, *Corresponding Secretary*; Dr. Elizabeth S. Kahler, *Treasurer*.

The Medical Society of St. Elizabeths Hospital met on November 12. A talk entitled "Experiences of a Psychiatrist in the European Theatre of Operations" was given by Major Morris Kleinerman.

The following officers have been installed for the year 1945-46:

Dr. Robert H. Groh, *President*; Dr. William G. Cushard, *Vice President*; Dr. George D. Weickhardt, *Secretary-Treasurer*.

Colonel Wallace H. Graham, M.C., A.U.S., addressed the **George Washington University Medical Society**, November 17, on the subject, "Combat Experiences in the European Theatre of Operations." Discussion followed, led by Lt. Colonel Walter H. Gerwig, M.C., A.U.S., and Captain Brooks G. Brown, Jr., M.C., A.U.S.

Dr. Joseph S. Wall represented the Society at a conference held by the National Coöperative Milk Producers Federation in Washington, September 24. Dr. Wall, Chairman of the Society's Committee on Public Policy, appeared on behalf of the American Medical Association. The subject of the discussion at the conference was the Wagner-Murray-Dingell bill.

Lt. Colonel S. Ross Taggart was appointed by the District Commissioners, November 27, to succeed Dr. Frederick G. Gillick as Director of the Health Department's Venereal Disease Bureau. Dr. Gillick resigned last August to accept a position with the United States Public Health Service in Philadelphia. During the interim Dr. Benjamin Chinn, director of clinical work for the Bureau, has been Acting Chief.

Colonel Taggart graduated in medicine from the University of Nebraska. He entered private practice in the District of Columbia in 1930 and for a number of years served as part-time instructor at George Washington University and Georgetown University Schools of Medicine. He also held a part-time post in the District's Venereal Disease Bureau from 1931 until 1941, when he entered the Army. He holds the Bronze Star Medal for his services in Belgium, Holland and Germany. He will take over his municipal duties about January 1, when his terminal leave expires.

The President of **George Washington University** recently announced the addition of 34 teachers to the faculty because of increased registration. Among those to be added to the teaching staff of the School of Medicine are Dr. Frederick G. Burke, Clinical

Instructor in Pediatrics; Dr. Clarence R. Hartman, Clinical Instructor in Medicine; and Dr. Joseph Ney, Clinical Instructor in Medicine.

Major General Shelley U. Marietta, Commanding General of Walter Reed Hospital, was awarded the Distinguished Service Medal by Major General Norman T. Kirk, Surgeon General of the Army, in recent ceremonies at the Hospital.

Garfield Hospital will receive between \$150,000 and \$200,000 as residuary legatee of the estate of Mrs. Alice G. Brandeis, who died October 11. This is the estimate made by the counsel who filed a petition for probate of her will at the Register of Wills Office in District Court. The bequest was made in memory of the late Supreme Court Justice Louis D. Brandeis.

At the meeting of the **Executive Board**, October 22, two additional committees were created, Committee on Medical Care of Veterans and Committee on Insurance. The latter committee is to consist of three members of the Society and three claim adjusters.

At the same meeting Drs. Richard T. Sullivan and J. Ross Veal were reappointed the Society's delegates to the Federation of Citizens' Associations for the District of Columbia for the year 1946. The Secretary of the Society reported to the Board that he had been reelected to the Coördinating Council of the Washington Metropolitan Health Council. Dr. Wm. Calhoun Stirling was approved as Chairman of the Eighth War Loan Campaign.

Dr. John A. Reed, Chairman of the Society's **Committee on Relations with the Allied Professions**, has been notified that the following representatives of interested organizations will serve with him on an Interprofessional Conference:

D. C. Pharmaceutical Association, Inc.: Sam F. Higger, A. C. Taylor, Irving Tennyson, Harold Kinner, W. Paul Briggs and John E. Donaldson.
D. C. Dental Society: Drs. Karl H. Wood, Francis J. Fabrizio and W. Lawrence Smallwood.

Graduate Nurses Association: Misses Alice Stone, Inez Cadel, Annabelle Petersen, Pearl McIver and Edith M. Beattie.

In addition to Dr. Reed, Drs. Philip A. Caulfield

and Emmett G. Coiner will represent the Medical Society.

The Hospital Superintendents' Association was also invited to appoint representatives but their appointments have not been received.

Captain Jacob Markowitz, R.A.M.C., who had been reported missing in action in Malaya since February, 1942, has been released as a prisoner of war, his many friends here will be pleased to learn. This information was received by his mother, Mrs. J. Markowitz, Highbourn Avenue, Toronto, in September.

Captain Markowitz was interned by the Japanese after the capture of Singapore and was assigned to the Burma-Siam hospital which contained 9,000 Allied prisoners during the latter part of 1943. Most of the patients had become ill from tropical diseases while working on the notorious Bangkok-Moulmein railway. He is credited with having saved hundreds of lives with only the aid of makeshift instruments and the most meager of medical supplies.

Captain Markowitz was an Associate Member of the Medical Society of the District of Columbia from 1931 to 1933. During 1931-32 he was Professor of Physiology at Georgetown University. After leaving Washington he lectured at Toronto University and the University of Glasgow, Scotland. He has now been assigned to duty with the R.C.A.F. in England.

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review. After the reviews have been published the books will be placed in the New Book Section in the Medical Society's Library. There they may be examined at leisure but cannot be removed from the building.

The Romance of Human Architecture. MAURICE CHIDECKEL, M.D. Price, \$2.00. Pp. 107. Boston: Bruce Humphries, 1945.

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis, 1944, Volume V. New York: National Foundation for Infantile Paralysis, 120 Broadway.

Man Against Pain. The Epic of Anesthesia. HOWARD RILEY RAPER. Price, \$3.50. Pp. 337. New York: Prentice-Hall, 1945.

BOOK REVIEW

Global Epidemiology—A Geography of Disease and Sanitation, vol. 1. JAMES STEVENS SIMMONS, B.S., M.D., PH.D., DR. P.H., SC.D. (HON.), Brigadier General, U. S. Army; Chief, Preventive Medicine Service, Office of The Surgeon General, U. S. Army; TOM F. WHAYNE, A.B., M.D., Lt. Col., M.C., A.U.S., formerly Director, Medical Intelligence Division, Preventive Medicine Service, Office of The Surgeon General, U. S. Army; GAYLORD WEST ANDERSON, A.B., M.D., DR. P.H., Lt. Col., M.C., A.U.S., Director, Medical Intelligence Division, Preventive Medicine Service, Office of The Surgeon General, U. S. Army; HAROLD MACLACHLAN HORACK, B.S., M.D., Major, M.C., A.U.S., Chief, Dissemination Branch, Medical Intelligence Division, Preventive Medicine Service, Office of The Surgeon General, U. S. Army; AND COLLABORATORS. Pp. 504. Philadelphia: Lippincott, 1944.

Global Epidemiology, covering the Far East, India and Pacific areas, shows the basic preparedness of the Medical Department of the U. S. Army and Navy for this war. Undoubtedly, much of this information was gathered by Army and Navy medical officers and Allied military officers prior to the declaration of war.

The book would interest anyone who might wish to visit this area and is an excellent companion volume to Tropical Medicine. The reviewer enjoyed reading it very much and recommends it to anyone interested in epidemiologic problems.

P. F. D.

GUY WHITMAN LEADBETTER, M.D. (1893–1945)

With the fading daylight on Sunday, November 11, the life of Dr. Guy Leadbetter was suddenly and unexpectedly complete. Born December 12, 1893 at Bangor, Maine, he never lost his affection for the place of his birth and early youth. The distant slopes of Mt. Katahdin called him back for a period of summer rest each year.

Dr. Leadbetter was granted an A.B. degree by Bowdoin College at Brunswick, Maine in 1916.

He graduated from Johns Hopkins Medical School in 1920. His work in orthopedics began at Johns Hopkins Hospital in 1920–1921. The next year at Lakeside Hospital in Cleveland, he developed an admiration for the technical skill of Dr. Crile and laid the general surgical groundwork which was later to distinguish him. Upon his return to Johns Hopkins in 1922–1923 as Orthopedic Resident, Dr. Baer was first to criticize and then to approve his new-fangled one-handed suture ties and the clamping of blood vessels with both hands at once.

During 23 years of active practice in orthopedic surgery in Washington, Dr. Leadbetter was the recipient of many honors. Among these were world-wide recognition for his maneuver to reduce fractures of the neck of the femur, reported thirteen years ago, and more recently approval of his cervical-axial osteotomy of the femur in reconstruction of the hip joint in ununited fractures of the femoral neck.

A simple summary of his professional positions at the time of death is the best résumé of his life's work. He was Clinical Professor of Surgery at George Washington University School of Medicine, where he had been on the faculty since 1928. He was President-elect of the American Academy of Orthopedic Surgeons and a member of the American Board of Orthopedic Surgery. He was chief of orthopedics at Emergency Hospital where he had built one of the best fracture services in the country.

During peacetime years "Leaddy's" boisterous noon-day laugh in the dressing room was auditory evidence to the operating-room personnel that he and those around him were enjoying life and their part in it. In the course of the war, however, this cheerful sound was heard less than half as frequently because the major part of his time was devoted to his country. A share of credit for our orthopedic success in this war must go to him. As Secretary of the Orthopedic Subcommittee of the National Research Council, he helped formulate recommendations on equipment and procedures in his specialty for the military services; as a member of the Military Committees of the American Academy of Orthopedic Surgeons and of the American Orthopedic Association, he assisted in the proper military assignment of orthopedists going into the service; and as Orthopedic Consultant to the Secretary of War he inspected military hospitals,

reporting on the orthopedic efficiency of personnel and procedures.

Most important of all was the influence he had on his numerous young friends. We knew him as a man who was almost more than an amateur in mathematics, astronomy, paleontology, geology, anthropology and photography. In other words, he was intensely interested in the broadest phases of professional education. He gave thrilling lectures on Mayan and Aztec Culture and the origins of the American Indian. His reading interests included French, Spanish and German as well as English. He was always impressive as a surgeon who recognized immediately the chief problem and set about the most direct way to solve it. A splendid mechanical feeling made orthopedic manipulations simple. It was for these things that his alma mater, Bowdoin College, in 1942 conferred upon him the honorary degree of Doctor of Science.

Professional memberships included the American Medical Association, the Southern Medical Association, American Academy of Orthopedic Surgeons, American Orthopedic Association and the Medical Society of the District of Columbia.

On December 7 his son Guy received for him posthumous Honorary Fellowship in the International College of Surgeons. He was also a member of the Metropolitan Club, Cosmos Club, Lions Club (past president), Phi Beta Kappa Associates, Pan American Union, Past Master of Cathedral Lodge, and a Shriner, Almas Temple.

He is survived by his wife, Alice Charlotte; a son, Guy Whitman, Jr., and a daughter, Patricia.

DONALD STUBBS, M.D.

FRED REPETTI, M.D.

(1875-1945)

Dr. Fred Repetti, a general practitioner in Washington for thirty-five years, died November 24, 1945, at Doctors Hospital following a long illness. He had maintained his office during most of those years at 811 L Street, N. W.

Dr. Repetti was a native Washingtonian, born September 1, 1875. He received the degree of Doctor of Pharmacy from George Washington University in 1901 and graduated from the School of Medicine in 1906. The following year he began practicing in the District of Columbia. For a brief period, 1908-10, he practiced in Denver, Colorado.

He was a Fellow of the American Medical Association, an Active Member of the Medical Society of the District of Columbia since 1914, and a member of the Hope Lodge of Masons, the Scottish Rite and Almas Temple of the Shrine.

The only survivor is his wife, Mrs. Clara B. Repetti. They resided at 2850 Connecticut Avenue, N. W.

JOHN ALFRED WHITE, M.D.

(1894-1945)

Dr. John Alfred White II, Chief Medical Examiner of the Pennsylvania Railroad, died November 16, 1945, en route from Washington to his home in Philadelphia.

Dr. White was born in Clarksville, Arkansas, July 15, 1894, and was reared in Clarksville, Texas, where his father was a surgeon. He graduated in medicine from the Medico-Chirurgical College of Philadelphia in 1916.

During World War I he entered the Army Medical Corps as a Lieutenant, and served in France until he was wounded and captured by the Germans seven months before the Armistice. King George decorated him with the Military Cross of England; he also received the Distinguished Service Cross and the Croix de Guerre before leaving the Army with the rank of Major.

Dr. White devoted his years of practice to industrial medicine. He served as assistant to the Chief Medical Examiner of the Washington Terminal Company from 1923 to 1925. From 1925 to 1929 he resided in Altoona, Pa., where he was surgeon for the Pennsylvania Railroad, and from 1930 to 1937 in Cleveland, Ohio, as medical examiner for the Railroad. He was reassigned to Washington and maintained an office at the Union Station prior to his appointment late in 1944 as Chief Medical Examiner of the Pennsylvania Railroad System.

In February 1944 he became an Active Member of the Medical Society of the District of Columbia, transferring to Associate membership on January 1 of this year when he moved to Philadelphia. He was a member of the American Medical Association.

Surviving are his wife, Mrs. Margaret Scott Penn White; his mother, Mrs. Alice T. White; and a brother, Eugene T. White of Houston, Texas.

Varicose Veins—de Savitsch
(Continued from page 541)

very important to apply the adhesive tape in such a way that the inguinal fold is either avoided or covered completely, since one of the most distressing postoperative experiences so far as the patient is concerned is the irritation of the area while the patient walks. The patient is then asked to get up and walk once or twice around the operating table. This helps the distribution of the sclerosing agent to the smaller branches. An elastic bandage of the "Ace" type is then applied from the foot to the thigh. In order to facilitate unrestricted movement, the area above and below the knee for about 3 cm. is left uncovered. Postoperatively no special sedation is required. In sensitive individuals 5 grains of a salicylate coupled with $\frac{1}{4}$ grain of codeine every 4 hours is sometimes indicated. The patient is advised not to limit in any way his activities and to return to his duties. The elastic bandage is allowed to remain for 48 to 72 hours, but the sutures are left in place for about 7 days, when they are removed and the area covered with collodium. In adipose individuals it may be desirable to leave the sutures as long as 10 days, since the healing is sometimes substantially delayed.

The extremity is carefully examined after 6 weeks, and if any varicosities persist they are injected with a sclerosing agent, beginning with the most dependent portion. This final "retouching" is required in about 50 per cent of the cases.

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2. MCPHEETERS, H. O.: Saphenofemoral ligation with immediate retrograde injection. Ibid., 1945, 81, 4.

Gallbladder Incision—Cox and Forrest
(Continued from page 543)

or the patient was extremely ill, permission was given to leave the bed any time desired.

Usually, by the third day the patient was able to walk a short distance to a chair or to the bathroom. Convalescence seemed to be unusually rapid and free from pain.

The appendix, if present, was removed routinely except in the very old and the very ill. There were 53 appendectomies in these 100 cases so done. The appendix always was removed through a separate incision, this being a small gridiron incision in the lower right quadrant.

The time of hospitalization is given by groups, according to the number of days in the hospital. It is as follows for the 97 cases with a satisfactory recovery:

4	were in the hospital	3 days
5	were in the hospital	4 days
8	were in the hospital	5 days
19	were in the hospital	6 days
10	were in the hospital	7 days
21	were in the hospital	8 days
8	were in the hospital	9 days
8	were in the hospital	10 days
5	were in the hospital	11 days
4	were in the hospital	12 days
2	were in the hospital	13 days
2	were in the hospital	14 days
1	was in the hospital	62 days

Of the 3 deaths:

	AGE	SEX	CAUSE OF DEATH	DAYS IN HOSPITAL
1	72	Female	Cancer of gallbladder and metastasis	1
1	74	Male	Cardiac or pulmonary	9
1	39	Female	Toxic thyroid with attendant heart impairment	6

Which Is Weaker Sex—Observer
(Continued from page 560)

males are becoming more and more concentrated in this sex."

The male of the species, it seems, has had rough going, and the present prospect is not conducive to optimism about the future.

*Local Control
of
Medical Plans*

By the time these lines appear, meetings of the Prepayment Medical Care Plans Conference and of the House of Delegates of the American Medical Association will have been held in Chicago. There would be no point in these comments except that it is interesting to speculate on the probable outcome of the deliberations of these bodies. No matter how one may look at it, one cannot dodge the fact that organized medicine is faced with the greatest crisis in its existence. Regardless of the action taken by Congress, President Truman's health message has had profound effect upon medicine. Medical statesmanship is called for, and not of a small caliber either.

Your Observer reported in the November issue highlights of the Public Relations Conference held in October. One of the suggestions made at the conference was that "the formation of a nucleus for the development of a program for medical service on a national basis, in correlation with the various states which now have plans in operation, and to assist those states which do not at present have medical service plans" be undertaken.

Your Observer agrees with this proposal in principle. However, he has recommended to

the A.M.A.'s Council on Medical Service and Public Relations the organization of a Federation of State Medical Plans. This would assure local control but provide an opportunity for planning on a national scale.

There will undoubtedly be those who will, in the face of the President's program, take a defeatist attitude. This, in your Observer's opinion, is unwarranted. Let us proceed with our voluntary plans. The least that can be said for them is that they will provide a pattern for the future. Certainly that would not be an insignificant accomplishment. As a matter of fact, it may prove of the greatest importance to the future generation of physicians.

National Health Program—Truman

(Continued from page 564)

Insurance against loss of wages from sickness and disability deals with cash benefits, rather than with services. It has to be coordinated with the other cash benefits under existing social insurance systems. Such coordination should be effected when other social security measures are reexamined. I shall bring this subject again to the attention of the Congress in a separate message on social security.

I strongly urge that the Congress give careful consideration to this program of health legislation now.

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